CATHOLIC PARLIAMENTARY LIAISON OFFICE

CRS CATHOLIC RELIEF SERVICES

Reflections on Covid-19

Covid & Children • Covid & the State • Covid & Public Health
Covid & Education • Covid & Migrants

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"When evening had come" (Mark 4:35)

For weeks now it has been evening. Thick darkness has gathered over our squares, our streets and our cities; it has taken over our lives, filling everything with a deafening silence and a distressing void that stops everything as it passes by; we feel it in the air, we notice it in people's gestures, their glances give them away. We find ouwrselves afraid and lost. Like the disciples in the Gospel we were caught off guard by an unexpected, turbulent storm. We have realized that we are on the same boat, all of us fragile and disoriented, but at the same time important and needed, all of us called to row together, each of us in need of comforting the other. On this boat… are all of us. Just like those disciples, who spoke anxiously with one voice, saying "We are perishing", so we too have realized that we cannot go on thinking of ourselves, but only together can we do this.

The storm exposes our vulnerability and uncovers those false and superfluous certainties around which we have constructed our daily schedules, our projects, our habits and priorities. It shows us how we have allowed to become dull and feeble the very things that nourish, sustain and strengthen our lives and our communities. The tempest lays bare all our pre-packaged ideas and forgetfulness of what nourishes our people's souls; all those attempts that anesthetize us with ways of thinking and acting that supposedly "save" us, but instead prove incapable of putting us in touch with our roots and keeping alive the memory of those who have gone before us. We deprive ourselves of the antibodies we need to confront adversity.

In this storm, the façade of those stereotypes with which we camouflaged our egos, always worrying about our image, has fallen away, uncovering once more that (blessed) common belonging, of which we cannot be deprived: our belonging as brothers and sisters.

Pope Francis, Urbi et Orbi Blessing, 27 March 2020

Introduction

In January 2020, when the first reports emerged from China of a worrying new virus, and even in March that year, when South Africa went into a three week lockdown, few of us would have been able to predict the extraordinary impact of Covid-19 on all aspects of life.

It has claimed 90 000 lives in this country, devastated the economy and sent thousands into unemployment; social, cultural and religious activities have been curtailed; families have been traumatised in myriad ways; various pre-existing problems, from poverty to domestic violence, have been exacerbated; and suspicion and mistrust of the authorities, both political and medical, often fuelled by inconsistent or ill-considered directives, have bedevilled efforts to control its spread. All the while, corruption, the bane of our national life, was siphoning off money meant for protective equipment or social relief.

At the same time, much good has also come of it. All over the country, communities spontaneously mobilised to help those in need, especially during the early lockdowns, when so many people in the informal sectors of the economy suddenly found themselves without income. Welfare and charitable organisations responded magnificently, as did many businesses. Government, routinely the target of criticism for doing 'too little, too late', came up with a special grant for those rendered indigent and provided various other forms of regulatory and fiscal assistance. Its efforts may have been patchy, but they certainly made a positive difference in many people's lives.

It will take years, even decades, to grasp the full impact of Covid-19. Indeed, if it continues to mutate and throw up new variants, the disease may be with us indefinitely, like flu. All the more reason, then, to try to understand as much as we can about its societal effects. This is what the five papers in this booklet attempt to do. Each has been written by an expert in their field, and each tries to assess both the negative and, where possible, the positive aspects of the pandemic in their area of work. They provide interesting and accessible overviews, rather than highly-detailed technical analyses, and they all tell part of the story of Covid-19's impact on us and of how we responded – or, in some cases, failed to respond.

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We hope that you find the publication interesting, and we welcome any feedback or comments to info@cplo.org.za

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The South African State under Covid-19: An Overview

by Dan Mafora

Introduction

The spread, across world populations, of the novel coronavirus disease otherwise known as Covid-19 in early 2020 presented governments with the biggest public health emergency since the 20th century. In response to the threat posed by the pandemic, once it so became, governments swiftly moved to adopt emergency measures.

These measures can be categorised as embodying three different approaches. The first was to declare a state of emergency, the second was to enact special Covid-19 specific legislation and the third, which was the path chosen by our government, was to invoke existing emergency legislation. Indeed, on 15 March 2020, President Cyril Ramaphosa declared a national state of disaster under the Disaster Management Act, 2002 ("DMA"). It was an interesting choice, given that the Act was enacted in contemplation of natural disasters and not necessarily viral pandemics.

Following the declaration of a national state of disaster, the President later announced that a hard lockdown would be imposed first for a period of 21 days commencing on 26 March 2020. The purpose of the lockdown was to curb the spread of the disease through the imposition of certain restrictions. These are discussed in more detail below.

The restrictions imposed adversely affected several rights and this article will provide a brief overview of the impact on human, socio-economic, and civil and political rights, while also highlighting the roles which each arm of state – the executive, the legislature and the judiciary – was meant to play in response to the pandemic, as well as discussing relevant case law material.

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The Choice of the DMA

Many had expected the President to declare a state of emergency. A state of emergency is contemplated in section 37 of the Constitution and is also regulated in terms of the State of Emergency Act, 1997. Choosing to go off the beaten path, and in the light of South Africa's dark history with states of emergency, the President invoked the DMA. While under a state of emergency rights in the Bill of Rights would be suspended to the extent provided for by the Constitution, under a state of disaster such a suspension does not occur.

As previously mentioned, the DMA is perhaps better suited to natural disasters such as floods, runaway fires, or droughts (and that is indeed how it had been used in the past) and not to pandemics. As a result, the Minister of Co-operative Governance ("Minister"), being the Cabinet member responsible for its administration, exercised her powers in terms of section 27(2) of the DMA and

issued regulations that would govern the national state of disaster.

The regulations were published on 18 March 2020. They imposed several restrictions on everyone within the borders of South Africa. In addition, the President announced that he would deploy members of the South African National Defence Force ("SANDF") to assist the South African Police Service ("SAPS") with enforcing the regulations and ensuring compliance; an unusual deployment of the armed forces domestically.

… the messaging by government took on a kind of wartime rhetoric, with the call to "combat" and "defeat" Covid-19.

Impact on Rights

Section 11: Right to life

Unsurprisingly, the government motivated its rights-intrusive interventions as necessary for securing South Africans' right to life. However, the messaging by government took on a kind of wartime rhetoric, with the call to "combat" and "defeat" Covid-19. Even the President took the extraordinary step of appearing on national television clad in army uniform on the eve of the deployment of the SANDF in its domestic mission to assist the SAPS with enforcing the regulations. Well-intentioned as it may have been, it resulted in abuse of police power and the excesses of the use of force.

On 10 April 2020, Mr Collins Khosa was killed by members of the SANDF for allegedly refusing to comply with their directions. Mr Khosa's family approached the High Court seeking to hold the Ministers of Defence and Police respectively accountable for their failure to ensure that the members under their control acted lawfully in the discharge of their enforcement duties under the regulations.[1] Mr Khosa's right to life was ironically taken away by the same people it whose job it was to protect it. This episode was the first of many which may not have received national attention, but which highlight the relative ease with which security services may abuse the powers granted to them if left unchecked. As a result of the *Khosa* judgment, codes of conduct for both members of the SANDF and SAPS were developed to ensure that members acted within the bounds of the law.

Section 12: Freedom and security of the person

The right to freedom and security of the person was affected in two ways: directly and indirectly.

The first direct limitation of the right is found in regulation 4 of the lockdown regulations, which provided that, *inter alia*, a person who was clinically confirmed as having contracted or suspected to have contracted Covid-19, or had been in contact with someone who had contracted it, could not refuse consent for subjection to medical examination, admission to a health facility for quarantine or isolation, or for admission to mandatory treatment, isolation or quarantine. If consent was refused for any of the measures above, an enforcement officer had the power to place the individual in isolation or quarantine for a period of 48 hours while they sought a warrant from a magistrate for a medical examination of that individual.

[1] Khosa and Others v Minister of Defence and Military Defence and Military Veterans and Others [2020] ZAGPPHC 147; 2020 (5) SA 490 (GP).

This was an extensive limitation on the section 12 right, which provides that everyone has the right to bodily integrity which includes the right to have "security in and control over" their bodies and prohibits any medical or scientific experimentation (and arguably medical treatment too) without a person's informed consent.

Indirectly, the regulations imposed a punishment of a fine or imprisonment for a period not exceeding six months for any contravention of the regulations, which is a criminal offence. The regulations also included criminal sanction for conduct that was previously not a crime, including the publication or dissemination of false information about Covid-19. The possibility of direct imprisonment for these offences is a limitation on the right to freedom of the person insofar as it criminalised conduct that was previously lawful to engage in.

Section 16: Freedom of expression

As discussed above, the regulations made it a criminal offence to publish false information about Covid-19, a person's Covid-19 infection status, or any measure adopted by government to address Covid-19. In addition, any person who lied about their own Covid-19 status would also be guilty of a criminal offence and liable to a fine or imprisonment for six months. These restrictions are an encroachment of the right to freedom of expression, which is limited only to the extent that expression constitutes hate speech in terms of the Promotion of Equality and Prevention of Unfair Discrimination Act, 2000. Although the extent to which the authorities have enforced the prohibition imposed by the regulations is not clear.

Section 17: Assembly, demonstration, picket and petition

Under the regulations, all gatherings were prohibited except for funerals, which were also subject to capacity restrictions. This was regardless of whether such a gathering was for religious or political purposes. This restriction limited quite significantly the right to protest, which includes the right to convene a protest against any measure adopted by the government in response to Covid-19.

Section 21: Freedom of movement

South Africa's coronavirus response was described as being among the strictest in the world.

South Africa's coronavirus response was described as being among the strictest in the world. One of the rights severely impacted by the regulations was the right to freedom of movement. In this regard, the regulations limited the rights in the following ways:

a) Every person within the territory of the Republic was confined to their place of residence. In this respect, a curfew was imposed.

b) Travel between provinces, cities and districts was prohibited, with exceptions made for funerals, the transportation of cargo, the transportation of corpses and travel for essential workers.

c) All borders; land, air, and sea, were closed and no travel into or out of the Republic was permitted.

In addition, any travel had to be approved first and any person wishing to travel had to be in possession of a permit for that purpose.

Section 22: Freedom of trade, occupation and profession

Under the lockdown regulations, all businesses which did not render an essential service or manufacture, supply, or provide essential goods had to cease operations or provide such operations remotely. This affected, in particular, informal traders and other workers in the informal sectors of the economy, who were barred from earning a living or participating in economic life. In addition, persons involved in the manufacturing, distribution, and sale of liquor products were also prohibited from engaging in their trade as the sale and distribution of alcohol was prohibited. The same applied to the manufacturers and traders of tobacco products, whose sale was equally prohibited.

Conclusion

The measures adopted by government in response to the Covid-19 pandemic, and the imposition of restrictions through the DMA regulations, represented the first wholesale limitation of rights since 1994 and outside of a state of emergency scenario. We consider the role of constitutional institutions below.

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Separation of Powers

Parliament missing in action?

As discussed above, the government chose to declare a state of disaster by invoking the DMA instead of declaring a state of emergency as contemplated in section 37 of the Constitution, although this option seems to have been given serious consideration. The choice to invoke the DMA over a state of emergency declaration and the extent to which rights in the Bill of Rights were limited raises the question whether invoking the DMA was not a deliberate decision to create conditions which mirror those of a state of emergency without having to comply with the onerous provisions of section 37.

Once a state of emergency is declared under section 37, it is governed in terms of the State of Emergency Act, 1997 (Emergency Act). The Emergency Act in turn provides for continuous parliamentary oversight over a state of emergency. It requires the President to "la[y] before the Table in Parliament" any declaration of a state of emergency and any regulations, order, rule, or bylaw made pursuant to such a declaration. Parliament also has the power to disapprove of or make any recommendation in relation to any emergency regulations or any provision thereof. This power arguably also includes the power to amend such regulations.

Under section 37, the National Assembly possesses the power to decline to extend a declaration of a state of emergency. Where it votes to extend the operation of a declaration, the extension of an initial declaration may be approved by a majority vote of the members of the National Assembly. However, any further extension is subject to a resolution in favour of such extension by 60% of the members of the National Assembly. These resolutions may only be voted on following a public debate in the National Assembly.

The provisions of section 37 read with those of the Emergency Act ensure that Parliament maintains ongoing oversight over the conduct

of the Executive following the declaration of a state of emergency. Importantly, Parliament retains its power to make changes to legislation, including any subordinate legislation made pursuant to a declaration of a state of emergency.

The DMA on the other hand does not contain comparable provisions. Instead, the management of a state of disaster is exclusively led by the Executive and parliamentary oversight is scant. Of course, Parliament is granted the power of oversight by the Constitution. However, following the declaration of a state of disaster, Parliament suspended its activities on 18 March 2020 and only resumed its activities in mid-April. Its oversight of the government's Covid-19 response has been limited and has focused largely on the irregularities that arose out of the emergency procurement processes undertaken by the government.

The Minister, empowered by the DMA to make regulations, has enjoyed the unfettered power to amend, substitute and repeal regulations with no Parliamentary oversight. To date, the Minister has not laid any regulations "upon the Table in Parliament" for its approval or amendment. Given the extent to which rights in the Bill of Rights were limited, it is unfortunate that Parliament has played such a limited role in holding the Executive accountable.

Recognising this, the National Assembly is currently considering a Bill to amend the DMA through the insertion of provisions which will require the National Assembly to vote on a proposed extension of a state of disaster and gives the National Assembly the power to disapprove of any proposed state of disaster regulations, as well as providing for the lapsing of a state of disaster. Currently, the Minister enjoys the power to extend the operation of a declaration of a state of disaster without any parliamentary involvement. The Bill would strengthen Parliament's role in overseeing a state of disaster.

An amalgamation of powers by the Executive?

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Following from the discussion above, it appears that the Executive has assumed a central role in South Africa's response to the outbreak of the pandemic. Perhaps rightly so, as the arm of state with the capacity to respond to a rapidly changing and unpredictable situation.

However, some concern should be expressed around the amount of power exercised by the Executive since March 2020. Initially, the President announced the formation of the National Coronavirus Command Council ("NCCC") which would drive the government's response. It was not clear what kind of structure the NCCC was or whether it had been formed in terms of legislation. When announcing the lockdown and in several speeches following, President Ramaphosa gave the impression that the NCCC was a decision-making body, declaring that "the National Coronavirus Command Council [had] decided to enforce a nation-wide lockdown".

When questions arose around the legal status of the NCCC, the Presidency responded by explaining that it was a mere Cabinet committee, made up initially of 19 Cabinet members and then expanded to include all other members. This did not allay fears that executive power had been

exercised by a body that was not empowered by the Constitution to do so. Gradually, the language about the NCCC's role in the decision-making process around the government response to the pandemic changed, with the President emphasizing that Cabinet was the one taking decisions acting on the advice of the NCCC. To this day, the exact makeup, powers, and role of the NCCC are not clear.

To this day, the exact makeup, powers, and role of the NCCC are not clear.

As discussed above, the DMA itself grants the Minister wide-ranging power to make regulations in response to a state of disaster. There are no meaningful guidelines in the DMA about how this power is to be exercised. For instance, in the lockdown regulations, the Minister granted other Cabinet members the power to make and issue directions on a diverse number of matters, without them being directly empowered by the DMA to do so.

In addition, the extent to which the regulations impacted on fundamental rights raises the question whether the power has been used in a manner suited to the use of regulation-making power. Ordinarily, regulation-making power is such that it can only be exercised within a framework created by a primary statute. Having not been enacted in response to Covid-19, the DMA does not establish a meaningful framework to guide the Minister's exercise of this power.

In effect, the Minister has enjoyed plenary legislative power to legislate in areas where Parliament has itself never legislated and to sub-delegate regulation-making powers to her Cabinet colleagues who are not directly empowered by the DMA – all without any oversight or input from Parliament. This leads us to the conclusion that the Executive, in invoking the DMA, may have intentionally sought to circumvent parliamentary oversight of its activities and decision-making for the duration of the state of disaster.

Judicial deference: a cop-out?

In the early days of the lockdown the *Mail & Guardian* reported that the Minister of Justice and Correctional Services had contacted the Chief Justice to consult him on draft directions the minister had issued on the partial closure and operation of courts under the lockdown. In response, the Chief Justice had raised concerns about the propriety of the minister interfering in the functioning of the courts. He accused the minister of removing "the specific constitutional and statutory powers vested in another arm of state, giving them to the executive and then seeking to consult the bearers of those constitutional and statutory powers" on how those powers must be exercised. This the Chief Justice found constitutionally suspect and declined the opportunity to be consulted. Instead, as head of the judiciary, the Chief Justice delegated some of his powers to individual heads of court to determine the procedures for their respective courts in light of the pandemic.

Many assumed that the episode above would be a foreshadowing of the relationship between the courts and the Executive under the state of disaster. The point made by the Chief Justice was simply that the courts should not be subject to the rules made by the Executive and should determine their own. This assertive stance by the Chief Justice

unfortunately gave way to what may be viewed as a form of reticence on the part of the courts. Faced with challenges to the legality of Covid-19 regulations, the courts almost always chose to defer to the Executive. While judicial deference in appropriate cases is not in itself suspicious, the courts' increased propensity to defer to the government does raise a few questions. These are interrogated in more depth below.

Covid-19 Jurisprudence

Unsurprisingly, the advent of Covid-19 gave rise to a flurry of litigation in response to the measures adopted by government. I outline a few notable cases below.

The Minister's regulation-making power

The first notable challenge brought against the Minister was by Mr Ryno De Beer who sought to have both the declaration of a state of disaster as well as the resultant regulations set aside as irrational and unlawful. In the High Court, Davis J granted him that order; declaring the regulations adopted under Alert Level 4 of the government's risk-adjusted model for determining Covid-19 prevalence in the country.[2] The court found in favour of Mr De Beer, holding that the regulations were not rationally related to the purpose for which the regulation-making power was conferred. Unfortunately, the court's reasoning was both confusing and confused. The court conflated the test for the rationality of legislation with the proportionality exercise required whenever rights are limited under section 36 of the Constitution, in addition to not testing the individual regulations against the rationality standard to determine whether they met the threshold.

On appeal, the Supreme Court of Appeal overturned the High Court's judgment. It held that the High Court did not apply the rationality test properly, instead engaging in a proportionality exercise which it was not allowed to do in view of the case as pleaded by Mr De Beer. Applying the proper test, the Supreme Court of Appeal found the regulations to be rational and upheld the Minister's appeal.

… the advent of Covid-19 gave rise to a flurry of litigation in response to the measures adopted by government.

The second case worth highlighting was a challenge to section 27 of the DMA brought by the Democratic Alliance ("DA").[3] In that case, the DA challenged section 27 – which empowers the Minister to make regulations – as being unconstitutional. They argued that it amounted to an unlawful delegation of legislative power from Parliament to the Minister, that it allowed the Minister to create the conditions akin to a state of emergency without adequate safeguards, and that it displaced Parliament's oversight of executive action. The High Court was divided on the constitutionality of section 27, with a majority of two judges holding that it was constitutional, while one judge disagreed. The majority held that in the context of Covid-19 "it is impossible for Parliament to legislate, in advance, ways and means to deal with sudden foreseen or unforeseen calamities, it is best for it to delegate some of its functions ... The executive

[2] De Beer and Others v Minister of Co-operative Governance and Traditional Affairs (21542/2020) [2020] ZAGPPHC 184; 2020 (11) BCLR 1349.
[3] Democratic Alliance v Minister of Co-operative Governance and Traditional Affairs and Others (22311/2020) [2021] ZAGPPHC 168

would be better placed to deal rapidly, comprehensively and effectively with disasters in a way that Parliament cannot do".

For the majority, in this view, the Minister's wide power conferred by the DMA to make regulations, sub-delegate regulation-making power, augment existing legislation, and to amend, repeal or replace regulations without parliamentary oversight was perfectly constitutional. Matojane J dissented, pointing out that the section gives the Minister power to "legislate, interpret and execute [secondary] legislation that has wide-ranging limitations on the fundamental rights of all citizens without requiring that such legislation be first tabled in and approved by Parliament. He further stated that there was no reasonable explanation why, despite several interactions between Parliament and the executive *after* the national state of disaster was declared, no prior parliamentary approval or advice was sought by the Minister before drafting or issuing regulations, and that, because the DMA does not require parliamentary oversight (and undoubtedly because of Parliament's own dereliction of duty), the regulation-making delegation constituted a "comprehensive divesting of legislative power" by Parliament to the Executive.

… the DA challenged section 27 – which empowers the Minister to make regulations – as being unconstitutional.

The DA challenge was the first one which fully engaged with the kind of powers vested in the Minister in terms of section 27 and the implications of their exercise even under disaster circumstances. However, the majority judgment did not engage deeply with the issues raised by Matojane J in his dissent, and instead departed from the premise that the delegation of regulation-making power by Parliament under the DMA was lawful.

Parliament's failure to legislate

One notable challenge to Parliament's role in managing the pandemic came from the Helen Suzman Foundation.[4] Instead of attacking the regulations or the DMA, the Foundation took aim at Parliament, alleging that it had failed to fulfil a constitutional obligation to enact primary legislation to deal specifically with Covid-19.

More specifically, the Foundation had argued that section 7(2) of the Constitution placed a duty on Parliament to "respect, protect, promote and fulfil the rights in the Bill of Rights" and that Parliament's failure to enact emergency legislation in light of and in response to the spread of Covid-19 (also the Executive's failure to initiate such legislation) was a breach of the section 7(2) obligation. While accepting that "the threat posed by the pandemic would ... have triggered the duty in section 7(2) to take measures in the main to protect the rights of all impacted on by the virus," the court did not find that such duty was breached by Parliament's failure to enact Covid-19 specific legislation.

Rather, the court held that the various limitations on fundamental rights were as a result of the measures taken by the state in response to the pandemic. These measures were "grounded in the DMA and in particular the powers given to the Minister in terms of the DMA". It further held that while the regulations had had adverse effects on fundamental rights, they had as a "broad objective the protection of

[4] Helen Suzman Foundation v Speaker of the National Assembly and Others (32858/2020) [2020] ZAGPPHC 574 (5 October 2020)

various rights" and that because the Foundation did not take issue with the exercise of the Minister's regulation-making power and the content of the regulations themselves, it could not impugn the government's invocation of the DMA.

This unfortunately did not provide an answer to the Foundation's case, which was that there was a duty on Parliament to respond to the pandemic with specific and targeted legislation in order to respect, protect, promote and fulfil the rights in the Bill of Rights. The court's reasoning also does not address an allied concern that the measures taken by the Minister in the regulations have interfered extensively with rights in a manner that is an unprecedented use of regulatory power. The fact that other legislation which permits emergency measures to be taken is a separate issue, and a contentious one, given on-going debates about the DMA's fit to the current circumstances.

In this case too, the court deferred to the Executive's invocation of a statute as justification for dismissing the Foundation's case, in a matter which concerned the role of Parliament, and, in my view, missed the mark entirely, subsuming Parliament's primary legislative authority under the Minister's delegated secondary legislative authority.

Rights in the balance

In the avalanche of constitutional cases, very few dealt with rights claims. And of those few, only one was successful. It was brought by British American Tobacco (BAT),[5] in which it claimed that a regulation which prohibited the sale of tobacco and vaping products to members of the public in an effort to curb the spread of Covid-19 was unconstitutional. BAT argued that the regulation unjustifiably infringed the section 22 right of tobacco farmers, tobacco processors and tobacconists to freedom of trade occupation or profession; the rights of consumers of tobacco and vaping products to dignity, privacy, and bodily integrity; and that it constituted arbitrary deprivation of the right to property of participants in the supply chain for tobacco and vaping products under section 25.

In the avalanche of constitutional cases, very few dealt with rights claims. And of those few, only one was successful.

In the judgment of the High Court, we find for the first time a proportionality analysis which considers the extent to which the regulations limited or interfered with rights. The court considered the impact of the tobacco ban on the right of tobacco smokers to bodily and psychological integrity and found that, on the facts placed before it, the tobacco ban had led to heightened anxiety and stress and other adverse effects in smokers and other tobacco users. Considering the Minister's defence that the ban was aimed at curbing the number of Covid-19 hospitalisations, the court found that the number by which hospitalisations would be reduced, on the Minister's own version, was negligible and did not justify the extent of the limitation.

In addition, the court considered the ban to be an infringement of tobacco manufacturers, processors and retailers' right to property because it

[5] British American Tobacco South Africa (Pty) Ltd and Others v Minister of Co-operative Governance and Traditional Affairs and Others (6118/2020) [2020] ZAWCHC 180; 2021 (7) BCLR 735 (WCC)

prohibited them from disposing of and commercially benefitting from their property. The court also held that the right to freedom of trade, occupation or profession was limited, since engaging in the applicants' chosen vocations was made unlawful overnight and that none of these infringements were justifiable when balanced against the purpose for which they were imposed.

Importantly, the court held that when the Minister adopts measures in the regulations, such regulations must be rationally related to the purpose for which they are adopted but also that they must be necessary to achieve that purpose. In contrast to the cases previously discussed, the court here took a more interventionist approach, looking at the impact of specific regulations on fundamental rights and balancing them against the government's stated purpose.

Lessons and Conclusions

While the previous year has seen all of us try to navigate uncharted terrain, there are valuable lessons to draw from our experience of the Covid-19 pandemic. The first is that the people, through Parliament, should always have oversight of the activities of the Executive in times of emergency. This should include the power to amend, repeal or replace any regulations adopted in response to an emergency and that Parliament may not simply neglect its duties in light of changed circumstances. Cabinet ministers cannot enjoy the kind of untrammeled powers which they seemingly enjoy under the current circumstances.

The second is that the approach to challenging the lawfulness of measures adopted by government should focus not on the powers of the government officials, but on the impact the measures have on fundamental rights. The BAT judgment is a good illustration of how to strategically litigate around facially neutral regulations which have adverse impacts on fundamental rights. Rationality challenges simply do not afford courts the opportunity properly to have regard to the intrusive nature of government action.

The third is that we should not shy away from being critical of courts where they exhibit undue deference. As the discussion on Covid-19 jurisprudence above demonstrates, the courts in large part simply deferred to the Executive when challenges against the DMA regulations were brought. This in circumstances where the courts would ordinarily have been more interventionist. This may be especially so in the light of the severity of the pandemic, but that alone does not present the courts with an opportunity to shy away from interrogating the impact of executive action on the rights of South Africans on a more rigorous basis, not simply deferring to the wisdom of the Executive.

And finally, we must acknowledge the critical role played by civil society organisations which may not have been catalogued here. At the forefront of ensuring that government delivered on its promises, especially in relation to socio-economic rights, are civil society organisations who work tirelessly to ensure that the Constitution is not only aspirational but translates into real and concrete action in people's lives.

… we should not shy away from being critical of courts where they exhibit undue deference.

Children and the Covid-19 Pandemic: Always the afterthought?

by Joan van Niekerk

Introduction

From the start of the Covid-19 pandemic the Government of South Africa (GOSA) has failed to anticipate how various lockdown provisions and regulations might affect children's lives. Addressing the impact of the pandemic on children has been an afterthought rather than central in decision making processes. An example of this neglect is when lockdown was imposed on the South African population on 27 March 2020, a list of essential workers was published by government. Workers in animal welfare and protection were included on this list but not professionals who address the psychosocial and protection needs of children. Although the civil society children's sector was quick to begin advocacy action on this omission and child protection work was added to the list of essential services as a result of this advocacy, responses to the needs of children have continued to be reactive rather than proactive without thinking through the possible consequences for children of Covid-19 related decisions taken.

A similar gap occurred with the closure of the schools during the first three months of the Covid-19 lockdown. If schools were closed down, so were the school feeding schemes. Parents and caregivers were losing their employment and income and child hunger became a reality in the lives of millions of children, some of whom were already nutrition compromised. Again the NGO sector moved into action, and advocated for the distribution of food and permission for food to be distributed through schools and community collection points, aided by many churches, civil society groups and individuals.

Addressing the impact of the pandemic on children has been an afterthought rather than central in decision making processes.

The impact of the pandemic on children has been life changing and compromising of many children's physical, social and mental health, and educational progress. A study on the impact of the Covid-19 pandemic on children by Subramaney and others[1] concluded "*School closure has resulted in academic and social losses, but in South Africa there are further challenges due to limited access to online education, malnutrition (with the suspension of school feeding programmes), and the lack of provision of school-based therapeutic interventions for children with disabilities. Parents staying at home may not always translate into more child-focused interactions. Additionally, lockdown restrictions limit the potential psychological benefits of exercise and physical activity for children. Many South African children live in overcrowded, confined spaces and do not have access to private outdoor areas. Financial strain is a potent parental stressor and may have an impact on family stability. Co-parenting,*

[1] Subramaney U, Kim AW, Chetty I, Chetty S, Jayrajh P, Govender M, Maharaj P, Pak E. Coronavirus disease 2019 (Covid-19) and psychiatric sequelae in South Africa: Anxiety and beyond. *Wits journal of clinical medicine.* 2020 Jul 1;2(2):115-22

custody arrangements, and movement of children between households during lockdown might also lead to added stress in children."

Listening to children's voices

One of the most powerful ways of bringing the needs of children forward and understanding the impact of the pandemic on children is via the voices of children themselves. During Child Protection Week June 2020, Childline South Africa conducted a study with children aged five to 18 years who telephoned the counselling and crisis line or responded to questions on the Childline website. Counsellors asked children about their experiences of the pandemic and the impact of the prolonged lockdown on their lives. The report on this study revealed the many anxieties that children have about the disease itself and the consequences of the lockdown. In all 739 children, aged 5 to 18 years from urban, peri-urban and rural areas, responded to study questions.[2]

One of the most powerful ways of … understanding the impact of the pandemic on children is via the voices of children themselves.

A summary of the findings of the study revealed

46% of children expressed concerns about their health, the health of their families, death and the disease spreading.

31 % of children expressed concerns about their education, and the possibility that they would fail their grade.

33% of children requested more support in the form of home visits to check on them, free counselling and emotional support, someone to talk to and to report abuse to. This emphasises the need to break the isolation of children during lockdown via services such as Childline's toll free crisis and counselling line and web/chatroom-based counselling services.

Children's responses reflected the need for further emotional support:

20% expressed feeling worried, afraid, scared and/or stressed;

17% said they did not feel good, happy well or fine;

15% responded that they felt depressed;

Only 19% expressed happiness at home and feeling well/good.

Other concerns expressed by children in this study included loss of employment of family members, damage to the economy, food security, and hunger, missing friends and having to remain at home.

A similar project was initiated by the Commissioner for Children, Western Cape who invited children to share their experiences of the Covid-19 pandemic.[3] Children's comments from these two sources are integrated into the text below to illustrate the impact of the pandemic on the lives of children.

[2] Full report available at www.childlinesa.org.za

[3] Full report available at https://www.westerncape.gov.z(a/childrens-commissioner/resources

Education

> *"I am worried about failing and having to repeat the same grade next year"* Child, 10 years.
>
> *"Our education and our lives is (sic) on hold because of Covid-19"* Child, 16 years.
>
> *"School has changed drastically, the way we operate, the seating arrangements, the period times shortened, and we don't have break/ interval to rest our minds and relax. Rushing everything, trying to finish the curriculum. I miss the freeness (sic) and the tension-free environment where one can walk around the corridors and have no fear of the other person."* Child, 17 years.
>
> *"Having to adapt to a new and different way of schooling happened so suddenly and unexpectedly. It came with a lot of confusion and fear. At some point, it felt overwhelming…. There were times when I felt like giving up"* Learner, 18 years.
>
> *"The teachers were under pressure and living in fear, not wanting to die due to Covid-19. So, they acted impulsively, not wanting to come close to anyone and teaching uncomfortably. Due to that, learners suffered academically."* Child, 17 years.

The closure of schools during "hard" lockdown was considered essential for curbing the spread of the virus, and although lockdown has been shifted to less onerous levels, parents, children, educators and child rights activists have expressed many concerns about the impact of lockdown and the loss of school learning hours and days on the progress of children in education. Many believe that the lockdown and lack of or limited access to learning has exacerbated the educational opportunity and achievement disparities, with children from previously (and still) disadvantaged communities having the least access to learning opportunities during lockdown and thus falling further behind more advantaged schools and learners. Although many schools began programmes of web-based learning, children without access to data were unable to learn using electronic media, and educators in the poorest of schools and deep rural areas were unable to develop the materials suitable for online learning. The Department of Basic Education estimated that only 20% of learners had access to electronic learning.[4] Some educators were inventive in encouraging children to continue learning and when lockdown was lifted to levels four and three, developed work packs for children and dropped these off at central points in school feeder communities or pick up at school. Subramaney and others state that "School closure has resulted in academic and social losses, but in South Africa there are further challenges due to limited access to online education, malnutrition (with the suspension of school feeding programmes), and the lack of provision of school-based therapeutic interventions for children with disabilities."[5]

The Department of Basic Education estimated that only 20% of learners had access to electronic learning.

Children consulted on school closures and the shift to electronic education noted the need to develop new learning skills including

[4] South African Paediatric Association, 2021

[5] Subramaney U, Kim AW, Chetty I, Chetty S, Jayrajh P, Govender M, Maharaj P, Pak E. Coronavirus disease 2019 (Covid-19) and psychiatric sequelae in South Africa: Anxiety and beyond. *Wits journal of clinical medicine.* 2020 Jul 1;2(2):115-22

acquiring more autonomy and self-direction, learning to balance their responsibilities in the home with commitment to schoolwork, become more self-motivated and monitor their own mental health.[6]

Both children and parents expressed anxiety about Covid-19 infection of children if they were to return to school despite paediatric associations, paediatricians, public health specialists and informed educationists all encouraged the opening of schools, arguing that the risk-benefit ratio is clearly favourable to returning to face-to-face teaching, especially as the risks of infection for children, and children infecting educators, are low. The Daily Maverick noted "The extended period of school closures (March 2020-June/July 2020, depending on grade, and again during July-August 2020) has had immense ramifications on children's nutrition, learning, cognitive development, socialisation and mental health."[7]

The extended period of school closures … has had immense ramifications on children's nutrition, learning, cognitive development, socialisation and mental health.

Parents/caregivers have had to adopt the role of educator as a result of the lockdown, extended school holidays and alternate days/weeks at school. This has created increased stress in many families especially when parents/caregivers are working either in or away from home. Parents and caregivers with limited education may struggle to monitor and assist with home-based learning, further disadvantaging children from families at the lower end of the income scale.

It is important to note that school closures have contributed to increased numbers of school dropouts. A rapid assessment of the impact of Covid-19 notes "the longer marginalized children are out of school, the less likely they are to return… Being out of school also increases the risk of teenage pregnancy, sexual exploitation, child marriage, violence and other threats. Further, prolonged closures disrupt essential school-based services such as immunization, school feeding, and mental health and psychosocial support, and can cause stress and anxiety due to the loss of peer interaction and disrupted routines."[8]

Eddie Mhlangu, the spokesperson for the Department of Basic Education[9] commented on research that found approximately 500 000 children had dropped out of school since the onset of the Covid-19 19 pandemic. He said that apart from lockdown another factor that could have contributed to the high dropout rate is the rotation of school attendance with working at home days or weeks. When learners are not at school, they may lack support or supervision at home and school work may not be done and learners not helped when they do not understand the work. Mr Mhlangu stressed the need for partnerships between schools, parents, and communities to maximise efforts to motivate children to return to school. He stated "When members of the community vandalise schools, break in and steal food and equipment, they send a message that education doesn't matter,

[6] https://www.westerncape.gov.za/childrens-commissioner/https://www.westerncape.gov.za/childrens-commissioner/
[7] https://www.dailymaverick.co.za/article/2020-08-21-children-Covid-19-and-classrooms-10-point-plan-for-making-schooling-safe/
[8] United Nations and others. Covid-19 Rapid Needs Assessment. 2021: 44 https://www.dsd.gov.za/index.php/component/jdownloads/?option=com_jdownloads accessed 24th August 2021
[9] ENCA news, July 2021. https://www.youtube.com/watch?v=xmSGL3l4Sok accessed 22nd July 2021

which contributes to discouraging learners from coming to school."[10]

The impact of wearing masks in schools has been debated and researched. It is noted[11] that although wearing masks protects from Covid-19 infection, it does impact on learning, as learners and educators may experience a reduction in their ability to "communicate, interpret, and mimic the expressions of those with whom (they) interact. Positive emotions become less recognizable, and negative emotions are amplified. Emotional mimicry, contagion, and emotionality in general are reduced and (thereby) bonding between teachers and learners, group cohesion, and learning". Children with speech and hearing disabilities find communication whilst wearing a mask an even greater challenge. Voices may sound muffled, lips cannot be read by the deaf child, and articulation of words is more difficult from behind a mask. Children and adults with chronic lung conditions such as asthma also find continuous mask wearing a challenge.

The impact of the Covid-19 pandemic on physical health: nutrition, exercise, immunisation and access to health care

> *I am always hungry.* Child, 7 years.
>
> *"At school we are eating and learning and at home there is no food"* Child, 8 years.

A significant number of children in South Africa continue to have an inadequate diet both in relation to calories consumed for growth and development as well as the type of food. The price of food has risen considerably during the Covid-19 pandemic period, school feeding programmes have been slow to restart, and in schools which in the past have not qualified for school feeding programmes, there are increasing numbers of children who attend school with no/an inadequate breakfast and lunch and are nutritionally compromised.

The Covid-19 pandemic, … (has) revealed a stark divide between those who have access to adequate, nutritious, affordable diets and essential nutrition services and those who do not.

The Covid-19 pandemic, and the ongoing measures to contain it, have revealed a stark divide between those who have access to adequate, nutritious, affordable diets and essential nutrition services and those who do not. The politicisation of food parcels and government's efforts to control all distribution of food delayed children and family access to nutrition but was fortunately largely ignored by private organisations and individuals. South Africa also experienced some shining and inspiring examples of generosity and caring from civic minded public figures, such as Siya Kolisi (captain of the Springbok rugby team) and his wife, participating in the distribution of food to needy communities.

Although school closures and the alternate day or week attendance of learners to enable appropriate physical distancing in schools were, and possibly remain, necessary measures to prevent the spread of the virus, lost school meals continue to compromise the nutritional status of nine million children who could not or cannot access the National School Nutrition Programme every school day. For many, school meals

[10] https://www.iol.co.za/sundayindependent/news/lockdown-sees-20-year-record-in-south-africas-school-dropout-rate-26b5c24a-aa3b-439f-a742-0021d4005911

[11] United Nations and others. Covid-19 Rapid Needs Assessment. 2021: 44 https://www.dsd.gov.za/index.php/component/jdownloads/?option=com_jdownloads accessed 24th August 2021

are the primary source of reliable and nutritious food, and the gaps in restoring the feeding schemes rapidly and to all who need to benefit, increases acute malnutrition or wasting among these children.

The 2020 South African Child Gauge, focusing on nutrition and food security, noted that although South Africa is classsified as an upper middle-income country, high stunting rates, micronutrient deficiencies, and overnutrition in the form of overweight and obesity in children are prevalent. Acute malnutrition (including moderate and severe forms) remains a significant underlying cause of child mortality, being associated with one-third of all child in-hospital deaths. Children suffering from acute malnutrition are known to have compromised immune systems and are therefore more prone to infections such as Covid-19.

Children suffering from acute malnutrition are … more prone to infections such as Covid-19.

UNICEF states that these statistics are a call to action, stating that hunger is a form of child abuse, stating that even before the Covid-19 pandemic, "27% of children in South Africa are stunted, meaning that these children will not be likely to reach their full growth and development potential because of the irreversible physical and cognitive damage caused by persistent nutritional deprivations."[12]

Physical Health: The Department of Health has reported that many child health programmes have fallen behind during the pandemic. Attendance at immunisation and well-baby clinics has dropped, prescribed medication for chronic and acute conditions has not been collected. Some clinics developed a medication delivery service for patients, but this was not a universal service and has been mainly discontinued. Clinic attendance dropped due to fear of contracting the virus at the clinic. Early detection of health problems such as TB is essential for rapid treatment and prevention. The Department of Health has developed "catch up" plans to manage these concerns. While South Africa and the world were working on the rapid development of a Covid-19 vaccine, the use of existing life saving vaccines for serious childhood diseases declined in South Africa. Children experienced fears and anxieties about the health of family members and themselves.

> *"Mom might get infected (she's a sister) and then we get infected and we all die"* Child, 16 years.
>
> *"I worry about my mom, she is in hospital."* Child, 6 years.
>
> *"I worry about getting infected and passing the virus to my grandmother who is more vulnerable to this virus."* Child, 13 years.
>
> *"I am worried that people are dying and this Covid-19 is really spreading fast. What I am scared of is that it is going to kill my loved ones and me as well."* Child, 16 years.
>
> *"What worries me more is that most of our family elders have chronic diseases and they are the ones at risk of being infected so we might lose them without receiving help at an early stage."* Child, 12 years.

Fears about physical health could not be wished away or false reassurances given, but education for children about Covid-19, social distancing, hand washing and wearing masks, provided by the media

[12] UNICEF. 2021. https://www.unicef.org/southafrica/press-releases/slow-violence-malnutrition-south-africa

and schools was helpful in giving children a sense of having some agency in protecting themselves and their families.

Exercise, recreation, and play are essential for the optimal physical development of children and providing opportunities for social interaction and mental health benefits. Subramaney and others[13] noted that "Social interactions are an important component of a child's emotional development and their capacity for social competence."

The findings of the 2018 Report Card on physical activity for children in South Africa noted concerns for the lack of safe and accessible opportunities for physical activity.[14] The advent of Covid-19 and lockdown has further restricted recreational activities and increased sedentary behaviour among children and adolescents. Limitations on playing team sport deprive children of both exercise and mutually co-operative interaction.

> *"I really miss the interaction with my peers as social distancing restricts us even from standing or sitting near to each other to have a decent conversation so everyone can hear what you say."* Child, 15 years.
>
> *"I am worried because I play alone and every time my older brother shouts at me."* Child, 7 years, left in the care of her older brother.
>
> *"I am worried about staying at home and doing nothing"* Child, 8 years
>
> *"What I am most worried about right now is that I don't have freedom to go out and play with other children."* Child, 8 years.

The shift to online learning for many children is thought to have increased time spent with devices such as computers, gaming consoles and watching television. UNICEF[15] reported on research that clarified the advantages and disadvantages of increased access to the internet noting that that social media and video games do provide temporary escape from real life and offer valuable opportunities for social engagement. Popular games such as Animal Crossing and Minecraft were especially popular over the various lockdown periods, both of which are games that can be played with friends online or alone.

Social interactions are an important component of a child's emotional development and their capacity for social competence.

UNICEF is also mindful that there are risks for children when using the internet. Cyberbullying causes great harm to many children, there are predators online who are searching for lonely and vulnerable children, and for some children there is the risk of exposure to pornography and pornography addiction. Parents and caregivers need to be aware of the risks and develop strategies to protect their children. These include installing "netnannies" (programmes that prevent access to undesirable material), ensuring that device time is well managed, that devices

[13] Subramaney U, Kim AW, Chetty I, Chetty S, Jayrajh P, Govender M, Maharaj P, Pak E. Coronavirus disease 2019 (Covid-19) and psychiatric sequelae in South Africa: Anxiety and beyond. *Wits journal of clinical medicine.* 2020 Jul 1;2(2):115-22

[14] Draper, C. E., Tomaz, S. A., Bassett, S. H., Burnett, C., Christie, C. J., Cozett, C., de Milander, M., Krog, S., Monyeki, A., Naidoo, N., Naidoo, R., Prioreschi, A., Walter, C., Watson, E., & Lambert, E. V. (2018). Results from South Africa's 2018 Report Card on Physical Activity for Children and Youth, *Journal of Physical Activity and Health*, *15*(s2), S406-S408. Retrieved Aug 22, 2021, from https://journals.humankinetics.com/view/journals/jpah/15/s2/article-pS406.xml

[15] Subramaney U, Kim AW, Chetty I, Chetty S, Jayrajh P, Govender M, Maharaj P, Pak E. Coronavirus disease 2019 (Covid-19) and psychiatric sequelae in South Africa: Anxiety and beyond. *Wits journal of clinical medicine.* 2020 Jul 1;2(2):115-22

are switched off well before bedtime, devices such as computers and tablets are used in areas that all family members use, and focussing on open communication with children about their online experiences online. Children are often provided with devices that can access the internet with very little guidance and supervision. Many parents and caregivers lack the knowledge necessary for the protection of their children online and this contributes to the vulnerability of children.

Many parents and caregivers lack the knowledge necessary for the protection of their children online…

Mental health issues: the mental health of both children and parents/caregivers was affected by the pandemic. Emotional distress may be as contagious as infectious physical illness.

> *"I am losing my mind with boredom."* Child, 16 years.
>
> *"I worry that life will not go back to normal."* Child, 16 years.
>
> *"I am worried about my education; I am afraid that I am going to fail. I am also worried about many people that have died because of Covid-19 and I ask myself if my family and friends will survive."* Child, 10 years.
>
> *"I also worry about how the world will be after lockdown."* Child, 10 years.
>
> *"It (Covid-19) has disrupted us and we no longer have a future to something."* Child, 13 years.
>
> *"When they announced that there was to be a lockdown, I freaked out because I felt like it was the end of the world and we're all gonna die."* Child, 16 to 18 years.

Although the mental health of adolescents has received some attention during the pandemic[16], little attention has been paid to the mental health of younger children and parents. Parents and caregivers who have lost employment and the ability to feed their children and their families suffer depression, anxiety, loss of self esteem and a sense of personal competency. Children were not immune to these concerns as reflected in the statements below.

> *"My mother, she is not working, we have no food."* Child, 12 years.
>
> *"I am worried about my parents because they have lost their jobs. Now they are not able to look after us since their jobs are closed."* Child, 13 years.
>
> *"The economy because that will affect how the world will be after the virus is over and well, it's scary because look at countries like Zimbabwe."* Child, 13 years.
>
> *"I'm worried about the economy of the country, and the lives of our people."* Child, 16 years.
>
> *"I am worried about my brother's work, our parents are not working."* Child, 16 years.

Children often carry their anxieties silently, sometimes indicating how they feel via their behaviour. When children become withdrawn, seek extra physical comfort, do not eat or sleep well, are irritable and attention seeking, these are the signs that adults in their lives must take note of and open up opportunities for discussion. Sometimes an

[16] Sunday Times, August 22nd 2021; News 24, 23rd February 2021.

effort to protect the child from the reality of the family's situation can worsen a child's anxiety and depression as they sense parental distress. Usually, children find it helpful to talk and share problems with friends or teachers at school. Mask wearing and social distancing makes this more difficult.

It is important for parents and caregivers to spend time with their children, share some of their concerns without giving them a sense of responsibility for solving the family's problems, and to prepare them well for any changes that altered financial circumstances may necessitate such as moving to other relative's homes to enable the sharing of diminishing family resources.

There has been disagreement as to whether the pandemic has increased child suicide. Calls to the South African Depression and Anxiety Group helpline from adolescents who are feeling depressed have doubled, and Childline South Africa has experienced an increase in calls to the Childline Crisis and Counselling call centres during the pandemic. Any threat of suicide in a child or adolescent must be taken seriously and responded to actively and the child and parent/caregiver linked to a counselling service. In the Childline consultation with children discussed above, children clearly recognised their need for increased psychosocial support during lockdown, asking for visits by professionals to enable them to report abuse and talk about their concerns.

Violence against children: the increase or decrease in violence against children during the Covid-19 pandemic is difficult to assess for numerous reasons. The risk of infection and the need for social distancing, the hard lockdown, and school rotation system has resulted in children spending more time at home. They have less opportunities to report abuse and neglect that may be happening at home, as they have less time with educators to whom children most frequently report violence in the home. They may find the wearing of masks distancing and blocking of free and trusting communication with educators, after all who wears masks in the earlier experiences of children? the "baddies"! At home access to a device that enables reporting to a help line or online counselling facility may be controlled by the very person who is abusing them.

Children often carry their anxieties silently, sometimes indicating how they feel via their behaviour.

Despite this, civil society organisations working with children do report an increase in the numbers of children approaching them for counselling and protection after they have been victimised. The increased burden on civil society organisations may be linked to the fact that the Department of Social Development (DSD) offices close every afternoon at 14:00 for sanitising the offices, and social workers employed by DSD "work" every second day at home. Responses to the reporting of abuse to DSD, even via the process laid down in the Children's Act of 2005 (the regulations of which require contact with the child and a preliminary assessment within 48 hours) have been very slow, sometimes taking months. One might ask oneself, in the face of this apparent lack of service delivery, do children and adults with concerns about children believe that reporting has value? Children

may feel and be very vulnerable once they have reported and there is no immediate response. They may wonder if the abuser finds out about the report, will they be punished for speaking out?

The advocacy brief of the Children's Institute on Violence and Injury to Children during the Covid-19 pandemic[17] notes the statistics from the Red Cross Children's Hospital which reported that whilst injuries from motor car injuries decreased, unintentional injuries in the home increased mainly due to falls, burns and bites from the family dog. The reporting of non-accidental injuries decreased during the hard lockdown in 2020 in comparison to the previous year's figures but increased to slightly above the 2019 level toward the end of 2020 as hard lockdown was lifted from level five to level four and then three.

… a number of children requested that the alcohol ban remain in place as there was less violence in their homes and communities.

Of particular interest in the Childline consultations with children, a number of children in both the survey and a subsequent webinar convened with children via Media Monitoring Africa, a number of children requested that the alcohol ban remain in place as there was less violence in their homes and communities.

The Children's Institute Brief on Violence and Injury to Children noted some positive developments in responding to and preventing violence against children during emergencies: Community networks, including faith-based organisations were key to providing services to children and families; organisations such as Jelly Beanz and the social workers from Red Cross Children's Hospital offered services to children and families via Zoom and other internet and cellular telephone platforms; training programmes were exchanged between organisations with special skills.

Several recommendations relating to the prevention of violence in the family are made in the Children's Institute brief: there is a need to develop clear referral pathways between organisations to ensure that families and children receive the help needed; child protection should be designated an essential services during national emergencies; public information systems must develop and publish information that informs families and communities about the prevention of unintentional injuries; strategies to reduce intentional and unintentional injuries fuelled by the use of alcohol and other drugs should be developed and implemented.

Child pregnancy is a child protection issue. The recent release of Gauteng Department of Basic Education statistics on schoolgirl pregnancy has focussed on the pregnant girls and mothers, some as young as 10 years. Little attention has been given to boys and men and the exploitation of vulnerable girls. Any child under the age of 16 years (the age of consent to sex) who is pregnant should be assessed for sexual safety. Shocking as the statistics are, they are a reflection of the neglect of children during the pandemic, the vulnerability of girls, the need for supervision of children when they are not at school, and the country's failure to include boys and men in programmes that promote

[17] http://www.ci.uct.ac.za

responsible sexual behaviour. The Department of Basic Education life skills programme, unfortunately labelled as "sexuality education", should be prioritised teaching in schools. The materials focus on a range of essential life skills such as decision making, communication, stigma, etc. Educators need to be trained to present and prioritise the teaching of this critically important material to enable children to develop present and future relationships that are safe and based on mutual respect and facilitate decision making on behaviour and choices that optimise their futures.

Death and dying

> *"So many people are dying and getting infected with the virus, I worry that everyone is going to die."* Child, 9 years.

Those who work in child protection and child trauma have been aware of and attempting to alert government and other civil society organisations to the growing numbers of Covid-19 pandemic orphans. A recent report[18] has, using the available figures relating to the death of adults, noted that South Africa has over 67 000 children who have lost one or both parents to the illness and if one factors in grandparents who are the primary caregivers of children, the figure increases to 94 625 children. "Thus, Covid-19 will continue to fuel the loss of parents and family members, leaving children whose parents die with fewer options than existed before the pandemic." The study warns that for children and adolescents who have been orphaned, there is an increased risk of post-traumatic stress disorder, depression and suicide attempts. They are also more vulnerable to domestic, sexual, emotional, and physical abuse. The study concludes "Throughout this pandemic, children have been falling under the radar. Together, we must advance equitable vaccine delivery, avoid child institutionalisation and support families to care for children with deceased parents or caregivers."

Shocking as the statistics are, they are a reflection of … the country's failure to include boys and men in programmes that promote responsible sexual behaviour.

The loss of parents and caregivers from Covid-19 has a substantial impact on children and their anxieties. This is a disease which somehow feels far more out of individual and family control. Who will become infected, and when, is unpredictable as compared to the HIV and AIDS pandemic, largely transmitted through unprotected sex. The course of the disease is rapid and death may be sudden with no opportunity for anticipatory mourning and "preparation". Hospital visits to Covid-19 patients are not allowed. Children cannot say their goodbyes and have their last hugs. Funeral attendance is limited. Sometimes the notice of death takes time to reach the family and children. The movement of children to other caregivers is rapid and often poorly planned. Families who due to poverty and unemployment (presently at record levels) are unable to look after their own children, are suddenly obligated to take on more mouths to feed. The move to a new caregiver may involve a new school, a new community, making new friends. This instability is difficult for children who need stability, consistency and love to recover from trauma. Grant transfers from the deceased parent/caregiver to

[18] Hillis, Susan D et al. 2021. Global minimum estimates of children affected by Covid-19-associated orphanhood and deaths of caregivers: a modelling study *The Lancet,* Volume 398, Issue 10298, 391 - 402

the new carer are complex, slow, and require travel to Home Affairs offices where service is snail paced, with many caregivers having to return as further documents may be needed to complete the grant transfer.

Explaining death to children is both complex and painful when a child has been bereaved and the younger the child, the more difficult it is for children to understand that the deceased person is not returning to resume their role as a parent or caregiver. But it should not be avoided as it prolongs the period of mourning and adjustment that the child must achieve to restore a sense of balance and future orientation.

Explaining death to children is both complex and painful when a child has been bereaved … But it should not be avoided as it prolongs the period of mourning and adjustment …

Conclusions: The Covid-19 pandemic has brought challenges that sometimes seem overwhelming to those who work with children and families, in the same way that they are overwhelming to the children who are anxious, depressed, victimised, hungry and/or bereaved. It has presented the sector with a learning curve that sometimes seems to be on a downward trajectory and then at other times, a trajectory that is moving upward and onward. It has brought out the worst in some people such as greed and the willingness to engage in corruption or theft of money or food parcels for the hungry, but far more frequently, in has brought out the best in others: generosity, the willingness to share even the small amounts that one might have, uplifting care and mutual support from others who work in services to children, families and communities.

Recommendations: there is still much to be done to protect and provide for children in this and future national emergencies.

1. South Africa needs a national emergency plan, that is regularly reviewed and updated so that what has been experienced in this pandemic can be used to prevent the mistakes and optimise learnings for future national emergencies.
2. Responses to children must be prioritised and co-ordinated across government and civil society, inclusive of non-profit, faith-based, business and civil society organisations and structures.
3. National and provincial repositories of resources must be rapidly developed, structured and managed to enable children's needs are addressed as rapidly as possible.
4. The family must be recognised as a child's primary protection system. It is therefore essential to support families to enable them to support their children through crises.
5. Caring for the service providers: there has been some recognition for the medical profession during this pandemic. More awareness is needed that is inclusive of caring for other service providers who work in challenging circumstances that accelerate burnout, fatigue, depression and anxiety.

Resilience and Exclusion – Covid-19, and people on the move in South Africa

by Sally Gandar

The Covid-19 pandemic, its spread, and the associated lockdowns implemented by governments across the world have had devastating impacts socio-economically, as well as on the lives and livelihoods of individuals and communities. It has become axiomatic that the pandemic and lockdowns have exacerbated rifts and vulnerabilities already present in society and that it is those already marginalised who tend to be the first to feel the impact, and most acutely. For South Africa, with its shameful GINI coefficient, these rifts run along socio-economic lines as well as along other markers of in- and exclusion. Key to this is nationality, documentation type and immigration status. Unsurprisingly, marginalised populations are, and have been, the most vulnerable.

… the pandemic and lockdowns have exacerbated rifts and vulnerabilities already present in society and … it is those already marginalised who tend to be the first to feel the impact…

In ecology, the resilience or robustness of an ecosystem is measured by its ability to respond to shock. There are three types of resilience: the ability to withstand shock, the ability to bounce back, and the ability to adapt. These types of resilience are a useful lens through which to reflect on the first year and a half of the Covid-19 pandemic and associated lockdowns in South Africa and the impacts experienced by mobile populations in the country. There are various measures that have either bolstered or undermined this resilience. However, when thinking about resilience, it's also important to note that sometimes, for some people, resilience is actually forced resilience – they have no option but to be resilient, particularly when there are barriers to any other system – government or otherwise – that could or should provide them with a safety net. For many refugees, asylum seekers, and migrants in South Africa, this is the case. They have no option but to be resilient.

This essay reflects on the last 18 months under lockdown and the ways in which various government departments in South Africa have approached the protection of mobile populations – particularly refugees and asylum seekers – during the Covid-19 pandemic. It also reflects on the ways that this has forced people to be resilient, often at great cost. Coming out of South Africa's third wave, these reflections look at what was done, key learning from the various approaches adopted by the state, as well as what could have been done better. This reflection is not an attempt to speak for others, but rather to highlight key experiences in how various responses to the pandemic – state responses and otherwise – have increased levels of precarity experienced by people on the move. But they have also allowed for various forms of resilience to become even more manifest. Resilience,

forced resilience, and interconnectedness that can provide lessons for us all.

Securitization of migration – the context immediately before Covid-19 in South Africa

Over the past decade, there has been a trend toward increased securitization of migration in South Africa.

In order to understand the various ways in which the lockdown and the Covid-19 pandemic impacted persons on the move in South Africa, it's important to understand the context that existed prior to the pandemic. Over the past decade, there has been a trend toward increased securitization of migration in South Africa. This is evident in a series of amendments made to the Refugees Act, the most recent of which being the 2017 Refugees Amendment Act; as well as greater policy emphasis on securitization and the management of migration (whether voluntary migration or forced migration).

The Refugees Amendment Act

The Refugees Amendment Act, was signed into law in 2017, but had not yet been implemented. The trigger for implementation was the publication of regulations in the government gazette. That took place at the end of 2019, with the date of implementation set for 1 January 2020 – just two months before the first Covid-19 case would be reported in South Africa. In the public consultation processes the amendments were criticized by various advocacy groups. These criticisms centred on the fact that the amendments did little to remedy systemic issues in the implementation of the 1998 Refugees Act, and instead created more barriers and exclusions, as well as undermining rights and South Africa's commitments in terms of international refugee law. The newly implemented, and restrictive, Refugees Amendment Act is just one part of the context that existed immediately prior to Covid-19 reaching South Africa.

The National Security Council

At the same time that the Refugees Amendment Act and Regulations were gazetted, President Ramaphosa announced the establishment of the National Security Council – a body tasked with streamlining government's security-related work. The Minister of Home Affairs was one member appointed to that council. This followed a 2016 decision approved by Cabinet to reclassify the Department of Home Affairs to the Justice, Crime Prevention and Security Cluster. It had previously been under the Governance and Administration Cluster to the Justice, Crime Prevention and Security Cluster. This reiterates various policy shifts that have shown an increased focus on securitization and national security by the Department of Home Affairs, such as the White Paper on Home Affairs, published in 2019, which positions Home Affairs as central to national security, because of the DHA's role as an enabler of rights for citizens as well as the custodian of the identities of all citizens – a responsibility that ensures individuals can access services, as well as access the documentation needed in order to exercise the right to vote.

The Border Management Authority

A further pillar in DHA's increasingly securitized approach has been the Border Management Authority Act – a piece of legislation passed into law in late 2019, which will facilitate the creation of a border management authority which has been compared to the US Department of Homeland Security, Customs and Border Protection (CBP), and Immigrations and Customs Enforcement (ICE) in the United States. A key criticism of the shifts seen with respect to the Department of Home Affairs in South Africa, is that

> "*rushing to define problems like immigration as security problems – particularly national security problems – without compelling reasons to do so, is a mistake no democracy worth its salt should make. Premature securitization leads governments to treating symptoms rather than causes of social problems, and often in the most confrontational manner possible using the armed might of the state.*"[1]

These shifts, and the enactment of legislation restricting access rather than facilitating and regularising migration in South Africa are in line with policy, such as the White Paper on International Migration as well as the White Paper on Home Affairs, both of which position foreign nationals as a threat rather than a resource.

Migration: threat vs opportunity

Rushing to define problems like immigration as security problems – particularly national security problems – without compelling reasons to do so, is a mistake no democracy worth its salt should make.

It is in this context of shrinking of space for citizenship, and the characterisation of migration as a threat to be managed rather than an opportunity to be embraced, that Covid-19 arrived. South Africa's securitised approach to non-citizens in South Africa – driven by uninformed, non-evidence-based decisions – did not change and was not reassessed when trying to manage a pandemic and curtail the spread of Covid-19 both within our borders and across them. Instead, with securitisation and exclusion as a well-established lens through which non-citizens were already viewed in South Africa, the result has been the entrenchment of institutionalised xenophobia and increased precarity for non-citizens in South Africa, regardless of their documentation or immigration status in the country and the serious negative public health consequences of this approach. This is particularly dangerous where activities that claim to focus on national security may themselves pose a threat to the health of all in South Africa, as well as regionally.

"My fellow South Africans": Declaration of a National State of Disaster

On Thursday, 26 March 2020, South Africa entered into what has been described as one of the strictest lockdowns in the world. For an initial period of three weeks which was later extended by a further two weeks, no person was permitted to leave their place of residence except for essential grocery shopping, or an emergency, or if you had a permit showing that you perform essential services. The lockdown

[1] Daily Maverick OP-ED, *South Africa's emerging Department of Homeland Security,* by Jane Duncan, 20 January 2020.

was preceded by the declaration of a National State of Disaster on the evening of Sunday, 15 March 2020. In that speech, the President announced travel bans, cancellation of visas from high-risk countries, restrictions on gatherings, closure of schools, suspension of visits to correctional centres, and the closure of borders. Just a week later on 23 March 2020, he further announced the hard lockdown together with a package of extraordinary measures to combat the public health emergency as well as the economic impact that would be experienced in the coming weeks and months.

Citizen-centric language

In his first speech on Sunday 15 March 2020, President Ramaphosa began with the words "*Fellow South Africans*". In the speech on 23 March 2020 when the hard lockdown was announced, President Ramaphosa again started with the words "*My fellow South Africans*". This language is not unusual. It was a phrase repeated often in subsequent addresses by the President, as well as by other Ministers when speaking about the government's efforts and measures implemented to combat the spread of Covid-19 in the country. What this simple phrase does begin to show though, is that even at the highest levels, certain people within our country's borders were simply not held in mind. Language is power. Words matter. Particularly the words we choose at a moment where a country is declaring a national state of disaster as the result of a global pandemic – a moment where we should be drawing people together and opting for a unified response to a public health challenge.

What this simple phrase does begin to show though, is that even at the highest levels, certain people within our country's borders were simply not held in mind.

South Africa has approximately four million foreign born individuals in the country, according to both Statistics South Africa as well as the United Nations Department of Economic and Social Affairs. This includes foreign born persons with documentation and regularized immigration status, such as those on an asylum permit or a critical skills visa, as well as undocumented persons without regularized immigration status, such as someone whose visa has expired or who never had a visa. Foreign born persons account for between 4% and 7% of the entire population in South Africa. In this context the words we choose set the tone for our national response to a global health crisis – those words should ensure inclusivity and put forward a whole-of-society approach, where is it clear that our society is made up of diverse groups of people – citizens and non-citizens alike.

It was unfortunate that citizen-centred language was so pervasive at these early stages of South Africa's response to Covid-19, an approach that continued in the responses of specific government departments. In his initial speech, the President stated that the Covid-19 outbreak had been declared a national state of disaster in terms of the Disaster Management Act. Throughout the course of the week that followed, various ministers briefed the media regarding their portfolios. Many of these speeches also contained the words "Fellow South Africans". Plans were made to ensure provision of emergency water supplies to rural areas, informal settlements and public areas in response to Covid-19. Urgent meetings were held within the employment and labour sector, the student financial aid

scheme, the Minerals Council, and NEDLAC. The judiciary put in place measures aimed at curbing the spread of Covid-19 while ensuring that the courts continued to operate.

The Department of Home Affairs as the key to any other access

Silence from Department of Home Affairs

Virtually every government department and minister kicked into gear in order to understand the impact that Covid-19 would have on the sector for which it was responsible and to plan and implement contingency measures. Unfortunately, there was one ministry that appeared to be silent in respect of the constituencies it serves – the Department of Home Affairs (DHA). This silence is an overarching feature of this particular Department's response to Covid-19, particularly when it comes to the protection of refugees, asylum seekers and services for regional migrants. There are key lessons to be learnt from the deficiencies in the DHA's responses to Covid-19.

The announcement of the declaration of a national state of disaster, together with the border closures and visa suspensions, should ordinarily have included extensive engagement from the department responsible for managing the movement of people through South Africa's Ports of Entry – the Department of Home Affairs (DHA). This should have included announcements regarding precautionary measures at the various DHA offices across the country – whether those serving citizens (Civic DHA Offices) or Refugee Reception Offices.

For many governmental departments, it appears that refugees, asylum seekers and migrants were simply an afterthought – even an inconvenient afterthought.

Unfortunately, no official information was forthcoming. Specifically, no further information was provided to asylum seekers and refugees who rely on the country's five Refugee Reception Offices (RRO) for all their documentation and immigration status needs. Those offices are located in Musina, Pretoria, Durban, Gqeberha (formerly Port Elizabeth) and Cape Town and both asylum seekers and recognised refugees are required to visit them on a regular basis to renew their asylum/refugee documentation, as well as to obtain other documents such as a travel document or refugee identity document, or to ensure that their children are registered in their asylum/refugee file as dependents. Given that per day, roughly over 100 asylum seekers and refugees would present themselves at each of the country's RROs in order to renew documents or access other services the lack of official information was particularly concerning. The 15 March 2020 announcement by the President that gatherings of over 100 people were prohibited, would have had a significant impact on the queues at the RROs.

This forced invisibility and marginalization of migrants, refugees and asylum seekers in the responses to the Covid-19 pandemic has characterized much of South Africa's response. For many governmental departments, it appears that refugees, asylum seekers and migrants were simply an afterthought – even an inconvenient afterthought.

However, there are also even more concerning trends and attitudes that presented themselves in the context of South Africa's response to

the pandemic. In the paragraphs below, I will look at a handful of the most concerning ones – border fences, inaccessible social insurance and social protection, and 'essential services nationalism'. Interspersed with these examples of government department's responses to the pandemic and people on the move, I include some of the advocacy strategies and responses provided by civil society – inclusive of informal neighbourhood groups, non-governmental organisations, religious groups and others. Finally, this essay looks at the current context, amidst a third wave of infections and a phased roll-out of vaccines in the country.

It is concerning that one of the first acts that the government chose was to build a fence.

Building fences not access and protection

On 19 March 2020, a mere four days after the National State of Disaster was declared, the Department of Public Works and Infrastructure, Minister Patricia De Lille, announced her department would be using fast-tracked emergency procurement procedures (in terms of the national disaster legislation) in order to erect a 40 km fence at the Beit Bridge border. Although the use of the fast-tracked emergency procurement procedures was unnecessary, and a clear red flag that the procurement was questionable an estimated R37.2-million was budgeted for the project.

In many respects, this act typifies the state's early response to the pandemic (though not unique to the pandemic) – one of building walls and fences to exclude, rather than a response that acknowledges that our humanity and survival is intertwined with the survival of our neighbours, whether that neighbour is someone across a national border or simply someone living within one's community regardless of their socioeconomic status, social origin or nationality. Had that money been used for vaccine procurement, it would have ensured at least 200 000 doses at the discounted rate of USD 20 (or approximately R200) for two doses of the Pfizer vaccine. Instead, we were left with a fence that was simply cut when people needed to pass through it in order to move between South Africa and Zimbabwe or in order to cross the border to access food supplies.

It is concerning that one of the first acts that the government chose was to build a fence. This was before any Covid-19 information materials had been produced in relevant languages for South Africa's mobile populations. It was also before any communication had been provided regarding renewal of visas and asylum or refugee documents for those already in the country. It was also before any assurances had been provided regarding access to healthcare for non-citizens – something that South Africa's laws and policy provide for, but which is often not adhered to in practice.

In addition to the border fence, further investments were made in the securitizing of South Africa's borders during the pandemic, such as Minister of Home Affairs, Dr Motsoaledi investing in drones, dinghies and an army helicopter to police South Africa's borders. None of these investments served any reasonable or public health related purpose. Indeed, it could be argued that the wasteful expenditure on these

security measures has cost lives. The money spent could have been used to rectify inadequate provision of PPE at Department of Home Affairs offices. Further efforts to exclude and expel under the pretext of public health measures, the lockdown and pandemic, include mass deportations.

While fences were being built there were also other types of exclusions taking place. The RROs had remained closed, and as a result more and more asylum seekers were not able to renew their asylum documentation – usually renewable monthly, quarterly or every six months. While at the start of 2020 the number of active asylum permits was reported as just over 188 000 by the beginning of May 2020 – just six weeks into the national state of disaster – the number of active asylum permits had dropped to 118 842. Thus, in the first six weeks of the pandemic it is likely that up to 36% of asylum permits had expired and renewals were not possible.

Without a valid document, the document holder is often at risk of arrest and deportation. They also risk losing any formal employment that they may have. In addition, without a valid permit, bank accounts were frozen – a situation that increases vulnerability, particularly as the country was entering a 21-day hard lockdown. The week after the national state of disaster was declared, services at RROs were unpredictable. In some instances, the RROs limited the number of people permitted to enter the building to just 100 per day, in line with the restriction on gatherings promulgated in the Disaster Management Regulations. Once the hard lockdown had started, all the RROs across the country closed their doors. At the time of writing – over 500 days into the national state of disaster – those RROs have not resumed in-person services. In the initial period of the lockdown, the Department of Home Affairs proactively made arrangements for persons on immigration visas – usually this tends to be more privileged tourists and visitors, and those in South Africa on work and study visas. Blanket extensions were provided, and reassurances were publicly stated. For refugees and asylum seekers, no such communication was forthcoming.

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Perhaps it is in an emergency that we see just how important civil society is, not only as a watchdog, but also as a key role-player to help fill the gaps that are omitted from the government's response. At the very least civil society can advocate for greater inclusivity while highlighting overlooked access barriers – something of which activists, various communities in South Africa, and refugee/migrant-led groups have extensive experience. With the above two examples – the lack of any contingency plan amidst RRO closures, and the freezing of accounts by banks, civil society organisations across the country played a pivotal role, but it also meant that refugees, asylum seekers and migrants themselves were forced even more, to be resilient – there was no other option.

Frozen bank accounts, empty wallets

While several organisations assisting refugees and asylum seekers across the country began engaging with bank managers in their

geographic locations in order to secure a stay on the freezing of accounts when asylum documents expired, it was clear that a more systemic solution was needed. This resulted in many organisations, including the Scalabrini Centre of Cape Town and several law clinics across the country gathering evidence and experiences of accounts being frozen when asylum documents reached their expiry date. Scalabrini Centre addressed a letter to the Banking Association of South Africa – an industry association to which most of the major banks are members. The Banking Association facilitated engagement with all its members, which resulted in confirmation that bank accounts would not be frozen. This was a significant step in terms of securing some security for asylum seekers and refugees as we entered the 21-day lockdown. The solution wasn't foolproof, and there were (and continue to be) certainly some instances where accounts were still frozen, but the broader solution provided with the assistance of the Banking Association did two things. First, it ensured that there was, in principle, a commitment to not freezing bank accounts. Second, it ensured that NGOs working to assist refugees and asylum seekers might focus on the broader problem, rather than the impacts of that problem – that is, the problem of the lack of a commitment from the Department of Home Affairs regarding providing a blanket extension and publicizing that extension.

The Banking Association facilitated engagement with all its members, which resulted in confirmation that bank accounts would not be frozen.

The latter issue took longer than it should have. Many NGOs and organisations, as well as individuals, directed communication and correspondence to the Minister of Home Affairs. Much of this was done prior to the hard lockdown commencing. Despite this, in the first set of Directions published by the Minister in respect of the Disaster Management Act, it was clear that while provision had been made for persons holding visas issued in terms of the Immigration Act the Directions were silent in respect of refugees and asylum seekers. The only communication provided with regard to asylum seekers was a 26 March 2020 (the day the lockdown started) message to stakeholders from Asylum Seeker Management, which indicated that while RROs would be closed, anyone whose asylum or refugee document expired between 16 March and 16 April would not be penalized provided they renewed their document within 30 days of the lockdown being lifted.

Despite significant advocacy efforts, it took almost three months before the Department of Home Affairs issued formal Directions providing a blanket extension for asylum seekers and refugees. This was done through Directions published on 10 June, which extended all asylum and refugee documentation that had expired since the beginning of the lockdown to 31 July 2020. This was a significant step forward, but yet very little communication seemed to take place from the DHA in respect of these directions. This meant that even though the protection existed on paper, there was still very little understanding of it from other government departments, the police, and individual employers. In response, civil society therefore initiated broad communication campaigns as well as one-on-one engagements, which were vital in order to increase the reach and impact of the blanket extension. From those Directions onwards, further Directions have been issued by

the DHA from time to time. There is still very little in the way of a communication strategy with regard to the Directions, although the Department has begun putting updates on its website. In addition, there is little in the way of advance planning, with many of the renewed Directions only issued a day or two prior to the expiry of the previous ones. The impact of this on those who are now relying on blanket extensions, is extensive – it means being unable to plan ahead and an increased sense of living in limbo without any information about when they can expect in-person services to resume at the RROs. It also means that no new asylum applications have been, or can be, lodged since the beginning of the national state of disaster – which raises serious questions about South Africa's adherence to international refugee law and ensuring that it offers protection to asylum seekers.

Access to documentation and immigration status, as well as renewals, is just one of the many barriers experienced by asylum seekers and refugees during the Covid-19 lockdown in South Africa. Documentation is an enabler, allowing individuals to access and exercise additional rights guaranteed to them by South Africa's Bill of Rights, as well as an enabler of access to services. It is the first step in order to being able to live freely, secure employment, and access healthcare. During the pandemic, the issue of documentation and immigration status was also linked to access to relief parcels and relief funds. In the paragraphs that follow, I look at three examples where documentation and immigration status were used to exclude individuals from social insurance, social protection, and ability to provide essential services in the form of operating small businesses providing food security to local communities.

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Social insurance, social protection and documentation barriers: responses by the Department of Labour and Department of Social Development

Protections and insurance for those who lost employment

Social insurance comes in the form of funds that individuals can access when they fall on bad times. For example, employees and employers in South Africa are required to make contributions to the Unemployment Insurance Fund (UIF). When an individual becomes unemployed, they are able to make an application to the UIF, and provided they have made contributions and meet all the other eligibility requirements, can expect a payout over a number of months while they try to find other work.

The hard lockdown prevented all but essential businesses from operating. If you were able to work remotely, then you could continue to work, but for many – particularly those in the hospitality sector – this was not possible. This meant that for the initial three-week period, and then further, there were many businesses that simply could not operate. In order to mitigate the impact of this on such employment sectors, the Department of Employment & Labour announced the Covid-19 Temporary Employer-Employee Relief Scheme (TERS). This scheme was supposed to allow employers to claim money from the UIF

in order to continue to pay employees during the lockdown period.

While in theory the Covid-19 TERS fund was available to all employees, the immediate feedback provided by clients at Scalabrini Centre was that whereas their South African colleagues had received payouts, they and other non-citizen workers had not. This was despite employers submitting all the documentation and applications simultaneously. In some instances, it was evident that employers did not submit claims for non-citizen staff, often because the employer had failed to register that employee with the Department of Labour, regardless of whether the person had the requisite immigration status allowing them to work in South Africa. The delayed payments of TERS benefits to non-citizens was confirmed on 1 June 2020 by the Minister of Employment and Labour, where he indicated that

> "*this was occasioned by the fact that the UIF system identified contributors through South African Identity Numbers and Foreign Nationals had to be verified through interaction with the Department of Home Affairs and at times the South African Revenue Service (SARS).*"

… feedback provided by clients at Scalabrini Centre was that whereas their South African colleagues had received payouts, they and other non-citizen workers had not.

The Covid-19 TERS system was not the only system designed with the 13-digit South African Identity Document in mind, but the delays, without any form of contingency plan meant that many households went without any type of income for many months. For people in this situation, they were faced with an impossible choice – stay home and obey the lockdown, but starve; or go out and, risk catching or spreading Covid-19 as well as being arrested, just to try to find some form of informal work in order to bring in a small amount of money.

Emergency relief, social grants and the Department of Social Development

The Department of Social Development (DSD) had also announced social protection measures to try and assist people across the country. This initially began through the distribution of Social Relief of Distress food parcels. These food parcels were made available across all the provinces, but usually required that individuals apply or sign up to receive one through a dedicated website. In order to access the application, the first step involved provision of a 13-digit Identity Document number. Only certain people in South Africa are entitled to a 13-digit ID – citizens once they reach 16 years old, permanent residents and recognised refugees (although the latter must apply for the document at the RRO and it is only issued for the same time period as their refugee document, which is a maximum of four years). Further forms of social protection already in place at prior to the lockdown included various forms of social grants, such as disability grants, child support grants, old age pensioner's grant and others. All of these are accessible, provided one meets the eligibility criteria, by persons holding 13-digit IDs.

The statistics show that despite the fact that grants were already in place prior to the declaration of a national state of disaster, as well as the newly implemented emergency food parcels, very few non-citizens

accessed these support measures. By 15 June 2020, three months into the lockdown, only 112 foreign nationals had accessed food parcels through the official social relief system set up by the DSD in conjunction with the South African Social Security Agency (SASSA).

In addition to food parcel provision, at the end of April 2020 a further Covid-19 Social Relief of Distress grant of R350 per month (the Covid-19 SRD grant) was announced first by the President, and later by the Minister of the Department of Social Development. This grant was initially going to be available for a set six-month period from May to October 2020. When the grant was announced, it was clearly articulated that the reason for the establishment of this measure was to try and assist those in the most desperate of circumstances. This was a positive step, one that acknowledged the need for further social protection for those worst impacted by the lockdown and the pandemic. At the time of the President's announcement, there was hope that the grant would not simply be limited to those who it would be administratively easy to assist – persons with IDs. However, later when the regulations regarding the grant were published, it was clear that the grant was to be limited to persons with 13-digit IDs. In mid-May, the Scalabrini Centre of Cape Town wrote to the Minister of DSD and the National Coronavirus Command Council urging broad accessibility in respect of the grant – which would be a lifeline to many.

The response received was simply that the grant would be limited to citizens, permanent residents and eligible refugees. Scalabrini Centre continued to try and engage, and then eventually resorted to urgent litigation to extend the eligibility criteria to asylum seekers and special permit holders. That litigation was successful, and the Centre was able to work with DSD and SASSA in order to ensure the implementation of accessible systems that asylum seekers and special permit holders could use in order to apply for the grant. This was achieved by the end of July 2020. However, when tracking the impact of that litigation, we found that despite testing the system, and embarking on a strong working relationship with SASSA and DSD, by the end of the initial grant period (it was extended) no beneficiary of that litigation had received a pay-out of their Covid-19 SRD grant. This meant that an urgent lifeline that was supposed to assist those in the most desperate of circumstances, had not made any difference for asylum seekers and special permit holders.

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With further advocacy and engagement, the blockage was identified – the same one that had blocked and delayed payments of UIF TERS: the need for verification by the DHA before the corresponding government department could make the payment. In October 2020, DSD reported that whereas the cumulative number of persons paid out for the Covid-19 SRD grant was just under 20 million people, a total of 750 asylum seekers, and 1,117 special permit holders had applied for the grant but had yet to be paid out as they were still awaiting the verification process. For comparison, by 15 June, the figures for other categories of non-citizens who had accessed the grant were 3,336 refugees and 173,898 permanent residents, out of a

total of almost 16 million applications at that stage.

These numbers begin to paint an important picture. Data backs up the anecdotal experience seen by organisations and individuals working with mobile populations in South Africa – these populations are more vulnerable, and without social security and social insurance, the impact of the Covid-19 pandemic and lockdown resulted in increased vulnerability and precarity. In a recent publication from Statistics South Africa, it was shown that generally migrant respondents were more vulnerable than non-migrant respondents with higher percentages being unemployed. They were also the first groups ignored and left behind in the fight against Covid-19. At the time of writing, many of the Covid-19 TERS payments are still delayed. SRD grant recipients were finally able to receive their grant in February 2021, but reported even more barriers and stigma at point of service, where employees at the Post Office, unfamiliar with the asylum seeker document and special permits, sometimes refused to make the payment. During the course of many follow-up calls to grant recipients, I have heard stories of incredible hardship combined with significant resourcefulness, resilience and agency. Families that have lost their homes and now live in an abandoned car, or those that used the grant money they received, to try and start an informal business in order to try and secure an ongoing income in the face of major obstacles. The grant amounts received, have made a massive impact on the lives of those who were able to access them, despite all the obstacles and administrative barriers and delays *en route*.

At the time of writing, many of the Covid-19 TERS payments are still delayed.

There are important lessons to be learnt in these two examples relating to IDs as barriers to access. While mobile populations and communities are undoubtedly vulnerable, they are also resilient – and have to be. Migration, and migrants play a vital role in our economy, and have done so both during and prior to the pandemic. These vital roles were particularly evident in the provision of food security to various communities – both rural and urban – during the lockdown, with migrant run spaza shops being vital, but also through examples of efforts and initiatives by migrant communities to ensure that no one was left behind in the specific community that they call home. However, this is a further site where nationality-based exclusion was particularly evident during the lockdown.

Essential services nationalism: citizenship, spaza shops, food security

On 24 March 2020, the Minister of Small Business Development stated in a televised address regarding which businesses could remain open during the lockdown that was due to begin two days later that "*spaza shops that will open are strictly those spaza shops that are owned by South Africans, managed and run by South Africans*". The Lockdown Regulations that were published in the Government Gazette made no mention of nationality of ownership of shops that were permitted to remain open. The Minister's comments also clashed with statements made by other Ministers, urging residents to only shop at shops closest to where they

live, in an effort to stop people from travelling too much during the strict lockdown.

Despite the silence in the official regulations regarding the citizenship of owners of spaza shops and businesses that would be providing essential food access for their communities, the damage had been done. The Minister's televised and widely broadcast comments were more likely to reach wider audiences than a technical-legal document published in the government gazette. This was borne out as public sector employees including police officers began to implement the Minister's words, rather than official regulations. From as early as the day after the lockdown had begun, the media began to report on police shutting down so-called foreign-owned spaza shops. Further reports began to come in of local community members forcing foreign-owned spaza shops to close. However, there were tensions, as many communities also tried to force closed shops to open, as these were the most direct and closest places where they could access food supplies. Later, further regulations and directions were gazetted, indicating that businesses permitted to be open had to be registered, or have municipal permission. This was despite the fact that for many small and informal businesses, no such municipal permission process was available. Again, those who felt the greatest impact of these decisions seemed to be non-citizens.

Scalabrini Centre, together with Lawyers for Human Rights, were prepared to launch urgent litigation in order to ensure that any business providing essential goods and services – regardless of the nationality of the owner or staff of that business – should be permitted to operate during the national lockdown. Thankfully, such litigation was not necessary, as after a letter of demand was sent, new Regulations were published and specific communication publicised indicating that essential goods could be provided by all businesses. This was another win for inclusion and accessibility, but also for food security for all persons living outside of urban centres, or who would otherwise have had to travel longer distances in order to obtain essential goods. Spaza shops played a vital role during the lockdown, and continue to do so for various communities across the country.

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The examples provided throughout this essay, are just a few of the responses of government departments that were meant to help protect individuals. This includes the protection that one gets from being documented and having regularised immigration status in a country, or through the protection provided through social insurance and social protection funds. The failures and inefficiencies of the DHA seem to stand out quite starkly, and have impacted on the ability of other departments to deliver. It has also severely impacted on the ability of individuals to withstand shock, to absorb it, and to adapt – to be resilient. In April 2021 – over a year into the national state of disaster, and by which time every one of the 188,000 asylum documents in the country would have expired but for the blanket extension – DHA finally announced a plan to assist asylum seekers and refugees with the renewal of documents. This is currently being rolled out through

an email system. The system has not been smooth sailing. At the end of June, just over two months into the implementation of the email renewal system, only about 15% of asylum permits had been renewed and just over 10% of refugee documents. At this rate, it will likely take another 12 months before all the asylum documents that expired during the lockdown, have been renewed. A positive step is that the DHA has implemented longer renewal periods of up to a year for asylum documents. This will ease pressure on the Department, freeing up human resources to assist with reducing the renewal backlog as well as other backlogs within the asylum management system.

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While this essay has focussed on areas of exclusion, there have also been important spaces and instances where individuals and communities have come together in order to battle not only a virus that doesn't discriminate, but the socioeconomic impacts of the lockdown as well. In the Western Cape, various Community Action Networks (CANs) were initiated, as local communities tried to ensure that their vulnerable were protected and cared for. Many of these CANs have been cognisant of the additional burden of vulnerability occasioned by one's documentation and immigration status. This is an important site for ensuring better knowledge and awareness of the issues faced by mobile populations. Another example has been the focus of nationwide education and awareness campaigns, such as Sikhaba iCovid-19 on asylum seekers, refugees and migrants. These short, educational clips, were aired in all of South Africa's official languages, and also aimed to ensure better understanding of common issues and barriers across South Africa. While these are not silver bullets, they are significant victories in efforts to overcome discriminatory attitudes and the politics of exclusion.

In the migration sector specifically, the Migration and Coronavirus in Southern Africa (MiCoSA) Co-ordination Group has been a vital development and space for the sharing of resources and engagement with civil society, government and international organisations and actors across the region. The group has published important policy and issue briefs documenting the impacts of Covid-19 in the migration space. It has also provided a space where issues and barriers can be highlighted, and officials engaged in a non-confrontational manner – one often far more likely to achieve results.

Looking ahead: resilience, rights and the politics of exclusion

South Africa's legislation, including the Refugees Act and the National Health Act, as well as various governmental circulars, ensures that many people – regardless of documentation or immigration status – are entitled to access South Africa's public health system just like any South African citizen would. This is particularly applicable to asylum seekers, refugees, and migrants from the Southern African Development Community (SADC). During the lockdown, no clear communication was provided targeting undocumented persons, or those who may be or feel more vulnerable because of their documentation and immigration

status. This meant that when community healthcare workers were going door to door with screening initiatives, many would be left behind. This also means that when vaccine rollouts happen for various age cohorts, there are many people who will continue to be hesitant to engage and interact with state institutions for fear of victimization. The past 18 months of pandemic and lockdown has shown that advocacy is vital, but also that clear and targeted communication from official and reliable sources can make a significant impact on the everyday lives of some of those rendered most vulnerable in our society.

A securitised approach to migration, and the obsessive need for verification, has done a disservice to those that are meant to be protected by our state.

As we look ahead to the comprehensive roll-out of vaccines, it is important that advocacy, communication campaigns, co-ordination, and rights-centred dialogue continues. We are already seeing that despite commitments that undocumented persons – whether undocumented SA citizens or not – would be included in the vaccine rollout, that this has not properly materialised in the first phases of the roll-out. While there are positive steps ahead, ones which will strengthen resilience, there is much work to be done to ensure the amplification of marginalised voices, and to offer protection to those that need it most, including addressing vaccine hesitancy from all perspectives, and that people are not forced into resilience as an identity. A securitised approach to migration, and the obsessive need for verification, has done a disservice to those that are meant to be protected by our state. Who gets left behind matters, particularly in the context of a pandemic and global public health crisis, matters. There are direct links between the exclusionary decisions implemented by government departments, and the increased precarity of mobile populations in South Africa. We should be finding ways to strengthen resilience and assist all sectors of the population to bounce back, withstand the shocks we can, and adapt to the new normal. These adaptations must be inclusive as Covid-19 has certainly shown that approaches that exclude undermine our shared humanity.

Public Health in South Africa during the Covid-19 Pandemic

by Shrikant Peters

1. Introduction

In the last 18 months, South Africa has weathered three catastrophic Covid-19 wave peaks. These have been all-consuming and progressively deadlier as new variants of the virus take hold, exposing the limits of both our healthcare systems and the limited trust which our populace has in government to manage them. There have so far been over 80 000 confirmed deaths due to Covid-19, however government's excess mortality statistics indicate that when counted in combination with undiagnosed Covid-19 deaths and deaths due to disruption of our normal healthcare systems, the total number of deaths due to the pandemic could be three to four times as high.

Each deadly wave of the virus also brings with it a churning anger, guilt, and frustration; for many people leaving behind only the flotsam and jetsam of broken futures and families. For those left behind, the already fragile South Africa economy appears to have been thoroughly beaten into submission, unable to offer any opportunities for a better life, either for the starving beggar or the venture capitalist.

As South African healthcare workers, we are no strangers to a lack of resources. SARS-COV2 has simply become South Africa's fifth horseman of the public health apocalypse, joining HIV & TB, the Chronic Diseases of Lifestyle, Violence & Injuries and Maternal & Child diseases, to wreak havoc on the lives of citizens of this country, most commonly the poor and vulnerable. However, the sheer scale of mortality has been stupefying, with healthcare workers offloading bodies to mortuaries by the dozen every day, comforting families of both the old and the young, the infirm and the otherwise well, and trying to make meaning of the senseless suffering they have borne witness to these past few months.

However, within this overarching story of death, disrupted livelihoods and fear, has also come more nuanced stories. Stories of hope, of determination, of resilience and reform, of the possibilities of a new ways of doing things, and of a willingness to change both the system and the self by learning, as people, as teams, and as organizations.

In order to make any forward progress whatsoever, resilience will most certainly be required – as the community of global public health, we are still unsure as to how much longer the pandemic will still continue to affect our lives, adding to the unpredictability that has characterized our lives since the start of 2020. Even now, at the tail-end of the third wave, there is uncertainty as to when and how we should de-escalate our Covid-19 services, when we will re-escalate normal services, and how to reformat our healthcare services to withstand future external shocks within fixed budgetary envelopes. And pertinently, will we ever catch

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up the lost volume of services that the people of this country require.

Although uncertainty and confusion regarding the trajectory of the pandemic appears here to stay, we have however learnt a very great deal in the past few months – about ourselves, about our country, our economy, the trade-offs between lives and livelihoods, about the importance of teamwork and leadership, and about the important intersection between health and politics the world over.

A greater knowledge of these complex systems is foundational to improving them over time. It is thus incumbent upon us to re-define and sincerely pursue population health, remaining agile as we seek to implement systems of universal health coverage in an increasingly resource-constrained environment.

2. Healthcare Capacity and Triage

The central puzzle of economic theory is the very human problem of living in a world with infinite wants but only finite resources. From this unfortunate incongruity arises the concepts of opportunity cost, marginal gains in budget shifts and utility maximisation. Most of these concepts may seem abstract at first to those involved or interested in the field of health and healthcare provision, but this is only because of the disjointed way public healthcare is costed, purchased and provided in South Africa.

However, public sector healthcare providers in this country are forced to make economic decisions every day, by allocating scarce resources such as time-dependent ICU, High Care, emergency and operating room space to a set number of people who can maximally benefit from them. By increasing demand for acute healthcare beyond the limits of both the public and private sectors, the Covid-19 pandemic has been a great leveler in this regard, causing private sector facilities to also begin rationing their resources and turning patients away from their facilities, despite the profit incentive to admit as many patients as possible to the highest levels of care. This overwhelming demand makes the efficient allocation of scarce healthcare resources (in both the public and private sector) even more important.

The first step in responding to an overwhelming demand for healthcare is an accurate quantification of the current supply of healthcare resources. Whilst individual clinicians, disciplines and healthcare units may understand their own capacity and escalation potential, this is not necessarily the case for entire healthcare facilities and is certainly not the case for healthcare districts and provinces, which encompass public, private and non-governmental facilities. Current information systems do not allow for real-time, on-demand calculation of current free beds or average waiting times across hospitals in a geographic service area. Such systems would require investment in both software and personnel, data sharing agreements, and trust between different healthcare providers and the authorities that oversee them.

The second step would be to allocate these resources to the different healthcare services which require them. Even within the public sector,

healthcare disciplines (be they surgical, medical, paediatric, obstetric and others) have historically operated within silos, utilizing their own bedspace, operating rooms, bedside tests and investigations without regard for other disciplines also requiring access. The need to provide Covid-19 services has come at the further expense of other urgent care, with general, high care and intensive care beds, operating rooms and laboratory testing capacity of the former services being redirected to Covid-19. Being a highly infectious disease, with concomitant risk to other patients and staff, Covid-19 has had to be managed as even more of a service silo, with entire wards and other spaces in the hospital devoted solely to care of Covid-19 patients, and to the exclusion of other patient populations.

… healthcare providers are being asked to integrate the delivery of Covid-19 care more sustainably with other service queues.

Resource allocation up until now has been based on top-down political directive to respond to the urgent need for care during Covid-19 peaks. Over the long term, however, a more rational approach to resource allocation is required to ensure maximum efficiency. Increasingly, and with healthcare budgets shrinking along with the national gross domestic product, healthcare providers are being asked to integrate the delivery of Covid-19 care more sustainably with other service queues. This may result in more technical efficiency and less wasted resources. However, to fulfil the third step in healthcare resource allocation, we need to understand the utility of each healthcare service, based on the outcomes those healthcare services achieve. This automatically demands of us an interrogation of the quality of our healthcare services.

3. Healthcare Quality

The late Dr Avedis Donabedian, who is considered to be the father of modern healthcare quality improvement, developed a disarmingly simple framework to explain the nature of healthcare quality. He proposed that quality in healthcare should be understood in three separate but integral parts. This referred to the Structures, Processes and Outcomes of healthcare service delivery.

Healthcare Structures refers to the visible capacitation of the healthcare system, those items which healthcare providers need, enabling them to deliver a certain standard of care. These have been described by various international bodies such as the World Health Organization and Lancet Commissions as consisting of numerous component parts, such as the healthcare workforce, basic and complex infrastructure, sufficient finance capital, information systems, governance, leadership, policy direction, medicines and up to date technologies. These are ultimately dependent on the amount of money that government has available to fund the healthcare services. These building blocks are clearly necessary for quality healthcare, but on their own, they are not sufficient.

Healthcare processes refers to the actual delivery of healthcare services by trained medical professionals, by application of the principles of accepted medical practice. As scientists plying their trade, individual providers must be able to rationally diagnose and manage patients who present to them for assistance. This is ensured by rigour in both undergraduate and post-graduate assessment of students in all healthcare disciplines,

as well as routine clinical governance exercises which review adverse events, their contributory factors and mechanisms by which these may be alleviated in future.

Healthcare outcomes refers to results derived from healthcare provision and is the most intuitive of the three. When presenting to any healthcare facility, it is implicit that patients wish to be healed or cured, and have any physical or emotional distress which they may be experiencing relieved. Indeed, at face value, this may seem to be the only standard by which to measure healthcare service quality – the extent to which healthcare achieves the desired results of the patients who are our customers.

However, a focus on only healthcare outcomes avoids the fact some patient expectations are unrealistic, and that many conditions are incurable, despite best medical efforts. In these instances, it is important to still measure quality of healthcare as the proper practice of medicine and the provision of sufficient resources to enable comfort, care, and dignity to such patients throughout the healthcare experience.

Despite knowing the tenets of healthcare quality, as a country, we do not routinely measure the quality of our healthcare services, and neither individual patients nor healthcare authorities have a way of comparing quality of processes or outcomes between service providers or service queues. This applies to both the private and public sector. As such, patients are forced to make decisions based on assumptions, with public sector facilities assumed to be of low quality, and expensive private sector facilities assumed to be of high quality, without anything beyond anecdotal evidence in this regard.

… it is important to still measure quality of healthcare as the proper practice of medicine and the provision of sufficient resources to enable comfort, care, and dignity…

This makes the efficient and equitable allocation of resources almost impossible. Steps are under way to correct this, starting with development of the National Core Standards and Ideal Hospital and Clinic Frameworks. These initiatives are in their infancy and currently only measure the presence or absence of the necessary structures of healthcare. In order to truly empower both healthcare decision-makers in the National Health Insurance, and individual healthcare facility users, we will need a national system of quality measurement which is able to also measure the processes and outcomes of healthcare service provision. For now, clinicians will unfortunately continue to fight each other, in order to advocate for their own patients, based on urgent need for care. In time, this triage function will and should be settled by healthcare authorities, when they develop budget allocations based on the relative utility derived from the outcomes generated from such services.

4. The Importance of co-ordinated healthcare

Before getting to the complexities of outcome measurement across public and private sectors, there is a far more fundamental and urgent need, which the pandemic has demonstrated all too clearly. We need to ensure that the health system is able to provide all citizens with access to healthcare services, regardless of where they live and what income bracket they occupy. Previously, this was seen as a particularly public sector phenomenon, with overflowing casualties and long waiting lists

for urgent care and operations, whilst private sector facilities generally presented a façade of serenity and empty beds.

During pandemic waves, both public, and even more surprisingly, private sector healthcare facilities, were awash with unaccommodated patients, as beds and oxygen points filled up. Whereas government Service Level Agreements were setup in some provinces to enable the transfer of patients who required high care and intensive care services, these referrals have been few and far between due to a lack of capacity in the private sector for these services as well. Conversely, insured patients often required transfer from private facilities to their nearest public sector counterparts, which are used to processing large volumes of patients and escalating services as required during periods of excess demand.

Apartheid geospatial planning continues to thwart referral systems, resulting in tertiary academic centres of excellence being out of reach of marginalized and rural communities…

Healthcare access is of course a multi-dimensional concept, and includes not only the dimension of physical geographic access to healthcare facilities, but also the availability of appropriate healthcare professionals and services to the communities in which they are situated, acceptability of those services to patients, and a level of accommodation at such facilities which is able to allow admission and care of patients who speak a variety of languages, and may be differently abled. The final dimension of access, which has received a large amount of attention in recent times, is the affordability of care. This is inclusive of both direct costs such as payment for healthcare services to providers or insurers, as well as payments implicit in healthcare seeking, such as payment for transport or childcare services as required.

Thus, relative to income, seeking of healthcare services is far more expensive for South Africans who are unemployed, and who live in rural or peri-urban areas, where distances to healthcare facilities may be prohibitive. Apartheid geospatial planning continues to thwart referral systems, resulting in tertiary academic centres of excellence being out of reach of marginalized and rural communities, who must make use of an overburdened primary healthcare system with failing infrastructure and equipment.

Whereas public sector facilities follow standard clinical guidelines and algorithms to triage the overwhelming demand for time-sensitive care, the private does not impose stringent access criteria on services such as intensive care and surgical operations, and admits patients based on their ability to pay. Under Service Level Agreements established during the Covid-19 pandemic for intensive and high care services, private sector facilities were only allowed reimbursement for healthcare services rendered to public sector patients who fulfilled public sector criteria for such intensive and high care services. This introduces an unwelcome level of Clinical Governance and financial checks and balances, which was viewed by the private sector as an affront to individual clinician autonomy.

The National Health Insurance aims to improve levels of access to care by removing the need for out of pocket payments for healthcare services rendered. With all healthcare in the country being pre-funded

by general taxation, this would remove financial obstacles to care, and would conversely also increase the size of the healthcare market for private healthcare providers. Each healthcare facility, both public and private, would become its own cost centre, which would invoice the NHI for healthcare services rendered to citizens. In order to standardize access to healthcare for all citizens in the country, it will be crucial that all healthcare facilities and clinicians are governed by the same clinical guidelines and algorithms. Although it will require multiple engagements with a diversity of private stakeholders, standardisation between formerly private and public facilities is the only way to ensure equity, access, and efficient use of resources across the country, especially for scarce and expensive healthcare services

5. Public Health

Whilst the importance of maintaining healthcare access has made headlines in South Africa and around the world during the pandemic, it was readily apparent, especially in the early months of the pandemic, that actual control of the pandemic could only be established via non-pharmaceutical interventions – the use of masks, frequent hand sanitizing and social distancing. When practiced at scale, this had the power to limit viral transmission, replication and differentiation into numerous variants of concern. These were the actions of individuals, but the intervention which preceded it was national government-level communication and eventual legislation which enforced this behaviour. Some countries, like Australia, were even able to follow elimination strategies, by imposing hard lockdowns on their borders and rigorous contact tracing around cases and clusters.

Similarly, dramatic results were seen in South Africa during the protective national lockdowns, which sought to preserve Intensive and High Care services for Covid-19 wave peaks, by limiting alcohol sales, either completely, or at periods of known high consumption such as weekends. Routinely crowded emergency centres were eerily quiet on Friday nights, emergency operating rooms were empty, and intensive care services could be directed towards young Covid-19 patients who would have otherwise been palliated.

… standardisation between formerly private and public facilities is the only way to ensure equity, access, and efficient use of resources…

Whilst this level of government intervention is not sustainable for economies in the long-term, never before has it been so clearly demonstrated just how much more effective public health measures are at decreasing total disease burden than individual behaviour change strategies. As important as universal healthcare coverage is, it is still focused on curative medicine, which is focused on individuals who are already unwell, which is far less cost-effective than focusing on preventative measures in communities.

This focus on upstream causes of ill-health eventually leads one to the so-called 'Social Determinants of Health', which refers to the contexts in which we live, and which ultimately determine the quantity and quality of life which we can expect to achieve. These are all-encompassing; the quality of education we receive, the work which we perform, our levels of stress, our income and lines of access to credit, the safety of

our communities, the quality of our food, drinking water and air, the structures of our families, the agency of women, the power relations in our communities, the type of government which oversees us, and lastly, the accessibility to us of quality healthcare.

Medicine is a Social Science, and Politics is nothing else but Medicine on a large scale.

Most of these items are beyond the intervention of clinical staff, but they bear the brunt of decisions made by governments which affect all of the items above. The healthcare system is simply the universal receiver of all the ills of society and has a much larger effect on level of health than the healthcare system. This is the reason why the celebrated 19th Century physician, Rudolf Virchow, proclaimed that "Medicine is a Social Science, and Politics is nothing else but Medicine on a large scale".

Curative healthcare is and always has been a band-aid on the festering wounds of society – an endeavor which as noble as it is, must always form part of a 'whole of society approach' towards protecting and promoting health in all aspects of governance. The other positives of focusing on public health measures is that this focus on the macro-context removes the exercise of blaming individuals for their life decisions and apparent misfortunes, instead rather focusing on the context in which they operate and why it presents options and increases chances of events which are deleterious to one's health.

6. Social Solidarity

Another positive of the public health approach, is that it encourages the co-creation of health together with communities. This demands respect and voice be given to communities by health authorities. In recent weeks, South Africa has seen a wave of backlash against both lockdowns and the country's national vaccination programme. After more than a year of suppressed economic activity (political opportunism notwithstanding), protests and looting erupted in parts of Gauteng and Kwa-Zulu Natal, decimating industries there and wiping out billions of Rands in stock and infrastructure. Social distancing regulations were openly flouted for more than a week before relative calm returned to the streets.

Interestingly, the number of Covid-19 cases in Kwa-Zulu Natal remained muted over this time – subsequent epidemiological wastewater analysis has now confirmed that this time period resulted in multiple undetected super-spreader events, with viral transmission becoming exponential in the province, hidden by a decrease in Covid-19 testing numbers during the unrest. And now Kwa-Zulu Natal, as with many other parts of the country, once again finds itself with very few beds for Covid-19 patients.

There is also a growing community voice against the perceived adverse effects of vaccinations. Whilst supply of vaccines is currently the larger problem, there is a growing concern in health circles that vaccine supplies may soon come to outstrip demand, which in the long run is a much harder part of the equation to solve.

For now, anti-vaccination protests in South Africa seem to be only the ructions of a small but vocal minority, with more than two thirds of South Africans surveyed consistently indicating their willingness to be vaccinated. Discussions are being held as to whether vaccinations should

be mandatory, either for work, school or for the general populace. If such a rule were to be implemented, it would be sure to elicit a stronger and more concerted push-back from anti-vaccination movements.

Risk and benefit are always taken into consideration, for both clinical as well as public health interventions. Generally, clinical interventions generally proceed even though they are risky, for they provided targeted benefits to individuals who are at high risk of poor outcomes if left untreated (think of an appendicectomy for appendicitis). However, for Public Health interventions to succeed, they need to prevent people from falling ill in the first place and are applied indiscriminately to those at both low and high risk. Mass vaccination is justified due to marked preventative benefits and minimal adverse effects.

Ultimately, in democracies, being vaccinated and adhering to social distancing and any other future public health measures will depend on the level of trust between citizens and the government of the day.

7. The need for good Leadership and Management

For citizens to trust their government and its health authorities, politicians and civil servants involved in healthcare must demonstrate both effective management and inspirational leadership, which can catalyse the goodwill of the majority into social solidarity and economic growth. Clinical work in this country will remain an extremely frustrating and harrowing ordeal if frontline workers are not led by role models who are beyond reproach.

However impossible it may seem, even at the height of crisis, the health departments of this country and their sizeable, complex budgets have been a hotbed of corruption. From corrupt tenders to purchase of faulty and ineffectual healthcare equipment, personal protective equipment and transport vehicles, to the improper outsourcing of community mental healthcare services, to backdoor handshakes for irregular media campaigns – this country's health sector has seen it all.

… there is a growing concern in health circles that vaccine supplies may soon come to outstrip demand…

This level of theft and incompetence does not simply play out as farce for gob-smacked citizens – each rand misused is resource which could have been used to save the lives and livelihoods of South Africans; and the cost of corruption in healthcare should be measured in mortality.

The pandemic has definitely also given us our fair share of heroic leaders in the health sector as well – from Professor Salim Abdool Karrim who headed the first Ministerial Advisory Committee on Covid-19, keeping us updated with regular briefings and reassuring us that government's approach to the pandemic was based on the latest scientific evidence. Professor Tulio d'Oliviera also headed a team of scientists which became first in the world to describe the Covid-19 Beta variant, further highlighting the need for non-pharmaceutical interventions to continue alongside mass vaccination, in order to decrease viral replication and so limit immune evasion.

And politically, both the President and our former Health Minister, Dr Zwelini Mkhize, were lauded for taking the public into their confidence, addressing us sincerely as often as they could, to explain the need to

limit business activity, freedom of movement and the protection of our limited healthcare resources. Subsequent scandals have brought about an end to the Ministry and political aspirations of Dr Mkhize, who had to leave office under damning allegations of misappropriation of funds for governmental Covid-19 communications. The President is also being given shorter shrift the longer the pandemic wears on, and economic fallout from national lockdowns intensifies.

With limited budgetary space, the path towards improved population health is precarious for political leaders. As the country's economic growth continues to flatline or even regress, there is fervent support for greater access to welfare for those in need, which any government would be eager to deliver on, if the context allowed. The rate of unemployment in the country has never been higher, and both a universal Basic Income Grant and Universal Healthcare Coverage would represent a massive burden on the country's fiscus. Both would protect the vulnerable and prevent death. But the benefits of both pale in comparison to the potential benefits derived from broad-based economic growth.

For now at least it seems that we are simply on a path of limited economic growth and fractious politics – but this makes the need for good leadership and effective management all the more important.

8. Increasing individual Agency in Complex Adaptive Systems

Health is a complex concept to define, understand and measure, and only by understanding the systems which shape it can we adapt them to generate improved population health. Modern societies, for all their ills and successes, are simply the results of political settlements, which can be undone and reforged as they need to be. The need for improved health is front and centre of the global agenda, and is a driving force behind the sustainable development goals (SDG's), explicitly as SDG 3: Good health and wellbeing, but is also implicit as an ultimate goal of all other SDGs, from ending poverty (SDG 1) through to building strong institutions which can foster peace and justice (SDG 17).

A citizenry which is more engaged in the political decision-making around health can help improve the health systems which we inhabit. Legislatively, the architecture already exists in this country for this to begin. Communities are supposed to be integral members of their local health facilities and political structures, by sitting on hospital boards, clinic health committees and local government structures which pass integrated development plans. These are meant to ensure the accountability of our elected governments. Allowing otherwise marginalized persons to give input to prioritization and strategic development of government structures.

Up until now, these structures have not been fully utilized to their full potential, and most members of the population do not involve themselves with healthcare facility running or planning, with most unaware that such structures even exist. But they are vital to more effective and responsive healthcare.

… each rand misused is resource which could have been used to save the lives and livelihoods of South Africans… the cost of corruption in healthcare should be measured in mortality.

Similarly, healthcare workers need to start playing a more active role in understanding and adapting their own healthcare services according to the needs of the patients which they serve. Another of Rudolf Virchow's quotes is apt here too, that "the physician is the natural attorney of the poor". Thus, healthcare workers must reassert their agency and be ready to work together with healthcare authorities to ensure that clinics and hospitals are up to standard and improving over time.

It is incumbent on healthcare managers to allow both the general public and the frontline workforce to have greater participation in planning of services, as difficult as this may be. Frontline healthcare professionals otherwise inhabit the unenviable space of being some of the most highly trained and respected professional workers in the modern world, on one hand trained to save lives, but on the other disempowered by the healthcare systems within which they function.

The glue that can and must hold healthcare systems together is trust. Co-ordinated planning can only occur in fora which allow open discussion and sharing of diverse views, before plotting an agreeable way forward. The National Health Insurance is the macro-architecture which can build the structures required to advance better healthcare, but it will be up to citizens and healthcare providers to inhabit these structures and demand effective, efficient, and accountable healthcare services for all.

Social solidarity is important. But to make the system work we will need to grow trusting relationships between citizen and civil servant, and the public and private healthcare sectors.

9. More Resilient Healthcare Systems

A citizenry which is more engaged in the political decision-making around health can help improve the health systems which we inhabit.

The concept of 'resilience' has been touted as a fundamental aspect of being a healthcare worker – a professional who is able to withstand the pressures of overflowing hospital units, the psychosocial stressors of death and suffering which are witnessed on a daily basis. And to be fair, South African healthcare workers were already made of steel before the pandemic hit.

A routine hospital on-call shift for government medical doctors is generally in excess of 30 hours, during which they are expected to see to the needs of an untold number of individuals seeking their urgent care. A large percentage of these shifts are performed over and above their normal working hours, at nights and on weekends away from their homes and families. They are witness to the failings and inequity of society, and the inability of government services to adequately provide for the country's citizens. During the pandemic, nursing staff have been asked to oversee double the number of patients which they would have on normal shifts, to provide as many patients with the care necessary. I have seen porters, cleaners and administrative staff man vaccine centres with great enthusiasm, celebrating their participation in an endeavour which is safeguarding millions from further infections every day now.

At the end of three pandemic waves, the concept of individual resilience is beginning to wear extremely thin. Healthcare systems which are not built for flexible demand and supply of healthcare cannot sustainably

meet the demand for urgent care. Coming out of the pandemic, healthcare services will be decimated, waiting queues for medical appointments, procedures and treatments will be longer than ever before. Waiting for care has and will be the cause of death for a multitude of citizens over the coming months and year – this is the reality which state sector patients and the professionals who assist them are now dealing with.

As expensive as the National Health Insurance is, there is general agreement amongst the health systems community that a more just and equitable system must prevail over the current two sector division for the haves and have nots. It is inefficient, immoral, and unsustainable. Progress must be made towards such a system over time, and can begin without the use of more financial resources. The foundation of the National Health Insurance must be a more resilient healthcare system in this country.

… a more just and equitable system must prevail over the current two sector division for the haves and have nots. It is inefficient, immoral, and unsustainable.

This will require us to use the lessons learnt during the pandemic, to re-build the decimated routine healthcare services of the country. Never have we had such access to and investment in real-time incidence and prevalence dashboards. It is now routine to have quick access to dashboards of live information describing the last 24 hours of pandemic activity, broken down by demographic, geographic and co-morbidity data.

This level of health intelligence should be used to understand all manner of disease and injury afflicting citizens across all 53 health districts in the country and should factor into health promotion and healthcare plans and strategies. The effects of public health interventions are now readily demonstrable, and this makes establishment of cause and effect relationships identifiable, allowing health authorities to pinpoint the many upstream determinants of ill-health operating in various areas, leading to everything from infections, chronic diseases of lifestyle, inter-personal violence and injuries, substance abuse, maternal and childhood illnesses and mental ill-health.

With a better understanding of disease prevalence and incidence in the country, we can empirically approach healthcare service design, to maximise the utility we gain from services provided. With more healthcare attendance and workforce data, we would be able to better understand and equalize the pressures being placed on healthcare workers in this country and support them despite the increasingly restricted funding envelope. And with better health outcomes measurement, we would be able to understand the consequences of healthcare finance decision-making, maximizing its utility.

In the immediate response to Covid-19, an increasing use of epidemiological data would enable more proactive contact tracing systems, making elimination strategies feasible and negating the need for heavy-handed social restrictions and their consequent effect on the economy. This granular understanding of disease incidence could in turn allow for nuances in policy design, such as differentiated lockdown levels in smaller geographic areas of the country.

Access to better data alone would not lead to healthcare nirvana, of course. Given our lack of economic capacity to meet our quadruple disease burden, we will continue to make triage decisions, but by better use of health intelligence data, we will be far better informed in making these crucial decisions. Although the narrative of the National Health Insurance often concentrates on the singular central entity which will pool funds, set prices and purchases services. Yet the greatest change which is set to take place is the capacitation of healthcare districts and facilities to act as their own costing centres. This will require them to more rigorously report on their activity and outcomes in order to invoice and be reimbursed by the central NHI. This implies a level of health intelligence production and strategic management in the public healthcare sector which has never previously been realized.

10. Conclusion

The Covid-19 pandemic in South Africa has exacerbated the ills already present in our society; poverty, unemployment, inequality, and a political fractiousness and concomitant social unrest that already threatened to tear apart the project of nation-building at the seams. It has worsened our economic fallout and this disruption appears to have further locked us into a low-growth trap, with markedly deleterious effects on the social determinants of health in both the short and long term.

At the same time, the importance of pursuing and protecting population-level health has never been more important to national and global policymakers the world over. Until everyone has equitable access to Covid-19 vaccines, no one is safe. This thinking should be extrapolated to all other social determinants of health, in the interests of individual health, population health, and respect for human dignity.

… the greatest change which is set to take place is the capacitation of healthcare districts and facilities to act as their own costing centres.

The next all-encompassing global crisis which the governments of the world will soon face is that of climate change and its fallout effects, as global warming continues over the next few years.

Healthcare equity will continue to remain a pressing concern, to which all minds and resources, both in the public and private sectors must be applied, to better provide quality healthcare for all citizens of the country. But they must be first and foremost be enabled by government structures to lead healthy lives.

Ultimately, we need to think about what the ultimate goal of healthcare and health really is – what do we value as individuals and as a country, how do we understand ourselves as a new Republic, and how do we re-invent ourselves as a nation and an economy. What country is waiting to be born into this tumultuous new world? And what about that is worth fighting for, and how do we best fight for it?

Then how do we best and sincerely operationalize our hopes and aspirations, to turn them into the country we would one day like our descendants to be proud to call their home. The pandemic has clearly demonstrated that none of us is safe until all of us are. Now is the time to fight for the Public's Health.

Education in a time of Covid-19

by Anne Baker

1. Introduction

Nothing could prepare the world for the effects of the Covid-19 pandemic. Cristian Peralta SJ, in his his article "The Uncertainty of Pandemic" in the 25 May edition of *La Civiltà Cattolica,* outlines where we find ourselves in the third quarter of 2021: "We have all begun to realize with unusual clarity how fragile we are physically and psychologically, but the collapse of health systems and economies, changes in habitual behaviours, employment insecurity, social distancing and, above all, the awareness of death as an imminent possibility have all created in the world a generalized climate of incertitude and uncertainty."

For South African schools we began this uncertain journey in March 2020 when President Ramaphosa announced the National State of Emergency because the coronavirus had been detected in South Africa. It heralded an unprecedented effort to save lives at the cost of curtailing civil liberties. With the closure of all schools, little time was available for schools to organise how learning could continue for the children of South Africa. Well-resourced public and independent schools were able to move to learning online but the vast majority of schools were, and are, not sufficiently resourced to offer this. While the first and second waves of the pandemic made life difficult for school communities the third wave, currently being experienced during the writing of this article, has affected school communities far more. Children and young people are more susceptible to the Delta variant which is more infectious and thus spreads more rapidly.

So in spite of all the efforts made during 2020 and 2021, the Delta variant has brought even more challenges. The official state policy in response to the virus over the course of the 518 days at the time of writing this article has changed school life. Since the first detection of the virus, 2.69 million[1] people have tested positive and officially 79 421 lives have been lost[2]. Professor Lucie Cluver from the University of Cape Town and Oxford University says that current research estimates that one in every 200 South African children have lost a primary caregiver. This has enormous implications for schools and communities. In addition, many teachers have lost their lives to Covid-19, leaving school communities not only bereaved but necessitating extra work for those left in the school. Combined with efforts to 'catch up' lost learning, pressures on school leaders and teachers multiply daily. The Department of Education has an Adjusted Teaching Plan (ATP) to reduce the amount needing to be taught.

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[1] The figure of 2.69 million is based on positive test results and does not account for anyone who may have not been tested

[2] The Medical Research council estimates an additional 222 000 excess deaths have occurred in the same period. These are deaths above the norm at a similar time and the caution is that the official statistics are significantly understated.

In this article we share what has been done to support Catholic schools to date and what is needed as we continue to face the impact of Covid-19.

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2. Facing lockdown

Nothing illustrated the effects of the lockdown more clearly than Pope Francis's *Urbi et Orbi* address in a desolate, wet St Peter's Square. Using the story from Mark's Gospel of the disciples afraid in the boat in the midst of a storm, he likened us to these disciples: "We were caught off guard by an unexpected, turbulent storm. We have realized that we are in the same boat, all of us fragile and disoriented." In the South African Catholic school network we could describe the boats schools might find themselves in: either as a luxury yacht; or as a boat with a hole, slowly sinking. This disparity mirrors South Africa's economy and the social situation in which the majority of South Africans find themselves.

2.1. School Support

At the beginning of the pandemic CIE moved rapidly, using Zoom meetings in order to keep close contact with staff and with schools, and exploring how best to support them using the already established Principal's Forums. This has had the positive effect of communicating across the country very easily, when in-person gatherings were expensive and could only take place every six months.

With schools closed, the normal manner of supporting schools through Catholic regional service staff visits and staff development became virtually impossible. Like the rest of the world, those with access to technology converted to communication through digital means. This access, of course, varies from region to region and it must be noted that a stable internet connection is far from adequate in many parts of South Africa.

One example of how regional offices offered support to schools comes from the CIE Regional Office in the Northern Cape: The key was to keep in touch, stay connected, care for self and others, ride the storm together, support each other, be in it together. Psycho-social and leadership support was provided to Principals and school leadership during the lockdown. Support included:

- Frequent telephone conversations
- WhatsApp messages with Principals
- WhatsApp groups with Religious Education Co-ordinators, Designated Child Safeguarding Persons (DCSGPs), School Governing Body chairpersons and Owner representatives

One Northern Cape principal noted the following challenge for having in-person meetings: "As you know, we are currently working on a shortened curriculum with limited time at our disposal. In order to maintain social distance, we are working on the alternative day timetable model which means that all grades do not attend school every day and therefore have even less time at their disposal. School visits take up almost a day of tuition, which we cannot afford at this stage." Another said: "At present it is sufficient for me that we handle it as we have done so far so that we can maintain the Covid-19 protocol, i.e. virtual sessions."

While many independent and well-resourced public schools were able to move to online teaching, those without this infrastructure were left behind. Even parents who have online access at home have found virtual learning frustrating. A principal described this aspect: "parents who do have access to technology are sometimes frustrated because they are tired after their own day's work and often do not have the necessary skills to use the technology properly. They are also often irritated because it does not always work, i.e. there is a lack of reception, or the network speed is often poor. Furthermore, the cost of data also plays a big role.

"I'm exhausted. I'm getting a lot of headaches with online. It's a very long day and I feel like I am all alone stressing about studying for exams…"

Of some help, was that printed worksheets and text books were offered by some schools for communities without devices and internet access. Research indicates that WhatsApp has become the most commonly used medium to keep contact with parents and learners.

While most consider privileged independent schools able to use online learning easily, is not without great strain on teachers and learners alike. The following quote from a Grade 8 learner at an independent school highlights the loneliness and isolation of staying at home:

> "I'm exhausted. I'm getting a lot of headaches with online. It's a very long day and I feel like I am all alone stressing about studying for exams as I'm too tired after online classes. Am I alone feeling like this? The others don't say anything. I am trying my best though."

Meanwhile, Independent school leaders found themselves under pressure to offer instant online learning. As one principal said: "their experience of speedy implementation from 'a campus school to an online school for all grades' meant that they learned while they acted." He pointed out that "data and connectivity issues had to be sorted out quickly for individual learners and teachers."

Teachers' ability and willingness to use the technology was also a challenge. This is highlighted by the view of another principal: "It has happened so suddenly. As a school we did not have enough foresight to investigate this avenue and possibly implement smaller steps at the time". She added that they would have preferred to introduce remote learning in phases but that the pandemic made it "a matter of urgency". In 2020 she said: "at the moment it is all experimental, we are trying out different avenues. It also depends on the teacher, some are more willing than others and are more comfortable with experimenting with the technology available."

But even in these schools they faced the challenges of homes having only one computer with two or three children needing to make use of it at the same time, making the issue of accessible devices playing a major role for online learning.

A further effort during lockdown was psychosocial support offered by Dr Gloria Marsay, an educational psychologist. Dr Marsay facilitated a number of sessions on resilience and hope for CIE and other Catholic service providers on how to take care of oneself, teachers and learners during this time. She provided practical tools for self-reflection and stress management. Three sessions for

leaders and teachers based on the same concepts were offered. She developed a resource for schools entitled "Doing Hope".

In May 2020 Sr Kathy Gaylor OP, the Chairperson of the Catholic Board of Education, sent a letter of encouragement to all schools entitled "Of Care, Concern and Courage". Sr Kathy encouraged school as follows:

> Covid-19 confronts us with uncomfortable truths. Our lack of care for creation, and maybe for each other. We do not know when this pandemic will end, but it has already left us changed. We feel our vulnerability. In this darkness of uncertainty it is normal to be seeking sureness, clear answers. And there is very little that is sure. So we can perhaps lose our courage. It may also be that in this time we have experienced a sense of helplessness, of being frustrated in our search for opportunities to love and serve. With the opening of schools, these opportunities for mission present themselves again, and much courage will be needed.
>
> And yet, reopening our schools is an act of hope. Education orients us towards the future of our children and our society. If our hearts are open and full of compassion, we may yet hope, and move for that change that can be for the better – for all humanity and the societies we live in, and for the one world that is our common home. Let us remember: "Each of us is willed, each of us is loved, each of us is necessary." (Benedict XVI). And as we approach the great feast of Pentecost, May the God of hope fill you with all joy and peace as you trust in him, so that you may overflow with hope by the power of the Holy Spirit (Romans 15:13). We wish you strength and courage, and we thank you for your commitment.

In addition, on the Monday after Pentecost this year, school staff and owners were invited to a virtual prayer meeting to pray for all in the school communities who had passed away or suffered through Covid-19. This simple prayer service, attended by over 100 people from across South Africa was led by Sr Kathy Gaylor, and included an inspiring homily by Fr Peter-John Pearson.

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There is no doubt that the call to hope was (and is) central the mission of Catholic schools. Part of this mission is caring for and keeping children safe. A major concern was whether children were safe during lockdown. This concern was transmitted to schools in a letter to Principals and Designated Child Safeguarding Persons, with an emphasis on being alert to the possibility of child abuse or neglect:

> As some schools welcome learners back to school and others prepare for this, it is significant that last week was Child Protection Week with the theme "Let us protect children during Covid-19 and beyond." As Catholic schools we aim to make every day a child protection day.
>
> We are aware of how much effort is going into making schools safe for staff and learners to prevent the spread of the virus. The stress on schools is daunting and requires careful planning and monitoring of prevention efforts. This is about physical safety and protection but we need to be aware that children have been

out of school for a long time and may have faced many other serious challenges while at home. Staff themselves may have had to face similar issues and a pastoral response is therefore necessary for all in the school community.

It is these challenges that schools need to be aware of as the children return. Some of these but possibly not all could be:

- Emotional unsettlement in the home due to parents losing their jobs
- Hunger
- Loss of loved ones through Covid-19 or other illnesses
- Fear of the illness
- Witnessing violence in the home possibly gender-based violence
- Physical harm through being beaten by parents or siblings
- Sexual abuse

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Schools were recommended to implement a pastoral care plan to establish who would take care of the staff and their needs and to assist teachers to be aware and alert to the needs of the children. The recent release of statistics for teenage pregnancy by the Gauteng Department of Health emphasized this concern, as between April 2020 and March 2021 there were more than 23 000 teenage pregnancies, with 934 girls between the ages of 10 and 14 giving birth.

While the Catholic Institute of Education (CIE) has not conducted a recent survey to ascertain the effects of the latest wave of Covid-19, there is no doubt that much suffering and stress is present in our schools, and continuing support from those serving Catholic schools is necessary.

2.2. The reopening of schools

CIE was closely involved in discussions with the Department of Basic Education (DBE) in their consultations on how to open schools safely. The Minister of Education, the Director General and officials of the DBE are to be commended on the manner in which they consulted closely with all involved in schools, Unions, Governing Body Associations, civil society, and the National Alliance of Independent Schools Associations (NAISA) of which the Catholic Board of Education, represented by the CIE, is a member.

Due to these consultations, CIE was able to timeously issue Policy Briefs for schools explaining the protocols for school reopening which were promulgated under the State of Emergency statutes. CIE Regional Managers remotely advised schools on the protocols to be followed and how to ensure that they were compliant. We printed posters for primary schools and high schools with messages on how to keep safe during Covid-19, e.g. wash hands, wear masks, keep a safe distance. Schools with already complicated procedures for managing the school had to implement these new protocols to protect staff and children.

When, in May 2020, it was mandated by the DBE that all children have two masks and that schools follow Covid-19 protocols, CIE was

able to procure and administer the distribution of Personal Protective Equipment (PPE) for schools. The State supplied these to public schools but independent schools needed to source their own. Nearly 30 000 masks, as well as hundreds of liters of sanitizer and thermometers, were distributed to independent schools around the country. The bulk procurement reduced the costs of the PPE to schools. With funding obtained CIE was able to give PPE to low fee independent schools. Donations of sanitizer and masks were also delivered to some schools.

Independent and fee-paying public schools suffered major financial losses when parents stopped paying school fees during lockdown. Schools did their best to accommodate parents needs but some had to cut teachers' salaries or retrench them. In public schools that employ teachers paid by the School Governing Body (SGB) this was also a challenge. NAISA also highlighted, during the above mentioned consultations, the plight of independent schools. The DBE responded to these financial needs by lobbying National Treasury for funds and were granted R7 billion, for the Education Employment Initiative Grant (EEIG). The purpose of the EEIG was to

- Alleviate the impact of Covid-19 on Basic Education
- Serve as a youth employment stimulus
- Provide relief to schools affected by poor collection of fees
- Respond to systemic challenges in the sector
- Propel the sector into a new era post Covid-19

The money was allocated to provide education assistants at public schools, to ensure continued learning and teaching in a safe environment and to save SGB posts at fee-paying public schools as well as to save posts at government subsidised independent schools. This greatly assisted subsidised independent Catholic schools who applied for the funds.

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Further efforts by CIE were: advice on tax relief measures, assistance where possible with emergency feeding and upgrading of school sanitation.

Many educators and school administrators all over the world have found themselves in similar situations.

The CIE has close relationships with the International Catholic network, participating in research from which a Global Catholic Education Report was developed as well as sharing South African challenges and hearing the struggles of other countries. From these meetings it was clear that the challenges and suffering of the pandemic affected schools world-wide.

3. One of the major impacts for children is what is termed Learning Poverty

A child is considered to be learning poor if s/he cannot read and understand an age-appropriate text by age 10. Estimates of learning poverty are based on two main data sources: (1) the performance of students who are in school on international student assessments; and (2) the share of students who are out of schools and therefore assumed to be learning-poor. The pandemic is likely to have affected both components of the measure.

It could be that after a few years, children manage to catch up on the materials that they were not able to learn during school closures. In that case, estimates of learning losses would be reduced over time. In addition, the learning losses are measured for children who are ten years old today. As the crisis subsumes, new cohorts of children reaching 10 years of age in a few years would not have been affected by the crisis, therefore the measures of learning poverty should go back to their steady-state trend fairly quickly.

Still, the children who are now in primary school are affected, and not all of them will be able to catch up over time. The large increase in learning poverty in some of these simulations relates in part to lack of access to distance learning media, especially for children who live in poverty and/or in rural areas (UNICEF 2020). Without options to learn at home during school closures, disadvantaged children have fallen behind further. The Covid-19 crisis has thus magnified existing educational inequalities not only between countries, but also within countries.

An interesting dimension to the challenge learning poverty creates, is the transformation of the way in which education is assessed. There have been long debates around assessing learning abilities. The late Sir Ken Robinson highlighted how the education system we know today, growing out of the industrial revolution, had created a factory-like process. Children of the same age group are batched together and put through the system and come out as finished products ready for the world of work, even though we colloquially say that education prepares people to live in society. The reality is that most education systems are skills-focused with the intention to create future workers that keep the economy going.

Some fundamental debates in assessment have questioned whether it is appropriate to continue to place learners in age batches or if we should simply move learners across the curriculum based on their ability at certain points in time. Do we need to have an end of year exit examination at Grade 12 or should someone write matric when they feel ready to do so, whether it is anytime in their final year or even prior? Do we need to have secret examination papers which are only revealed at the time of writing, or would an open-book examination be better, where questions are sent to learners on demand. They then have the time to apply their minds and can be tested on understanding, rather than memory and working under pressure? The measurements of Education poverty created by the pandemic will require a radical thinking of assessment and learning, which may revolutionise assessment or further entrench long-held and seemingly immovable processes.

The future is uncertain in this regard, but what has become clear from the pandemic (which has entrenched and highlighted inequality) is that the wealthiest billionaires are now racing to see who will become the first trillionaire. The perception of justice in the world versus the lived reality of justice is now under scrutiny, e.g. in the final school examination, the perception that getting all learners to write the same exam at the same time creates fairness is no longer justifiable when the reality is at a most fundamental level some learners are writing

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those exams with an empty stomach while others have had many five-star meals on the road to writing. The pandemic has visualized this physical poverty which has a direct effect on learning poverty. The gap between the well-resourced schools and schools that serve the poor has become wider and education poverty follows the same trend

4. The South African Curriculum and the Adjusted Teaching Plan

The Adjusted Teaching Plan mentioned above is an example of how radical departures are being made as we deal with the pandemic. The South African curriculum is a remarkable achievement, firstly because it was created in a record time of five years, at a time when our entry into democracy was driven by a "we can do anything we set out minds to" attitude. The global average for curriculum development is 15 years, but the Madiba magic of the time and the unity of purpose by all stakeholders in the new democracy meant we achieved this feat in a third of the time normally required. After all it would have been considered unacceptable to continue to use the Apartheid curriculum and no one would have accepted a continuation of the old education system.

The second remarkable point of the South African curriculum is that it is homegrown. Unlike other countries in the region or the rest of Africa that follow curriculums (and have exit examinations set in former colonial powers) our curriculum was prepared by South Africans. It would have been easier to adopt a European curriculum, which would have immediately ended the use of the old curriculum, especially when all our neighbouring countries had done so since independence. This would have been quite justifiable and possibly welcomed, but we did not do that, opting to replace the Apartheid curriculum with a new one fit for an open, democratic society. While there are many disputes in education around the functional issues, such as how we resource schools, the approach to teaching, and who yields power in schools, the curriculum has been the one area that has not been contested.

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It is therefore no surprise that the curriculum is guarded somewhat preciously and is extremely prescriptive. Public schools and Independent schools writing the Independent Examinations Board (IEB) follow the South African curriculum. While the two systems may emphasise different abilities, the content is the same, in that independent and public schools teach the same thing at the same time if they follow the curriculum. The curriculum therefore serves not just an education function but a national building and social cohesion function.

The Adjusted Teaching Plan deviates from the curriculum and is a transitional tool that expands the outcomes of the curriculum over multiple years. This is the first time that such a deviation has occurred. Instead of prescribing, for example, what is taught in Grade 4, a learner can now be taught Grade 4 material in later years and over many years. This plan has been put in place to allow the department the time it needs to revise the curriculum completely, albeit with the intention of formalizing what they call a recovery curriculum.

A new policy will emerge and this new policy will allow for multiple year teaching on content. If anyone was to argue for a deviation from the curriculum two years ago, they would have met a wall of resistance from virtually every education stakeholder. The pandemic, however, has sped up the need for a radical departure and is creating a sea-change moment for education in South Africa. The CIE will, as it has done in the past, work in solidarity for the development of the recovery curriculum, ensuring that there is an option for the poor, and that what emerges maintains the fundamental dignity of learners and promotes justice for all.

5. Reflections on South African data

The National Income Dynamics Survey shows that up to 70% of teaching time has been lost. Furthermore, the levels of identified absenteeism shows that there were very few mitigating factors in place. An important measure in assessing mitigation is to look at an example of a social program which continued during the course of the pandemic and to see how well, or not, this program did. We will look at the National Schools Nutrition Programme (NSNP).

> "On average, 84% of the more than 10 million targeted 2021/22 learners had received meals over each of the DBE NSNP report cycles between 12 April and 15 June 2020. The DBE was mandated by a High Court ruling on 17 July 2020 to provide NSNP progress reports based on school self-reported data every 15 days. Inspections of the four reports produced between mid-April 2021 and mid-June 2021 indicate that between 78% and 87% of the targeted 10,707,186 learners received a school meal. However, much variation exists across provinces: Whilst the average proportion of targeted learners receiving school meals in Gauteng and Limpopo exceeded 95% over the four report cycles, the proportion of targeted learners fed in the Western Cape remained around 60%, whilst feeding in the Northern Cape declined from 80% to 34% over the two months, most likely due to increased learner absenteeism linked to rising infections in the province" [3].

While there was a significant level of access, the loss of 16% of learners is significant, as 1.6 million children did not access food. The earlier example we provided on assessments resonates here too. When you come to terms with the reality that 1.6 million children were food insecure, a significant number of them became vulnerable to education poverty.

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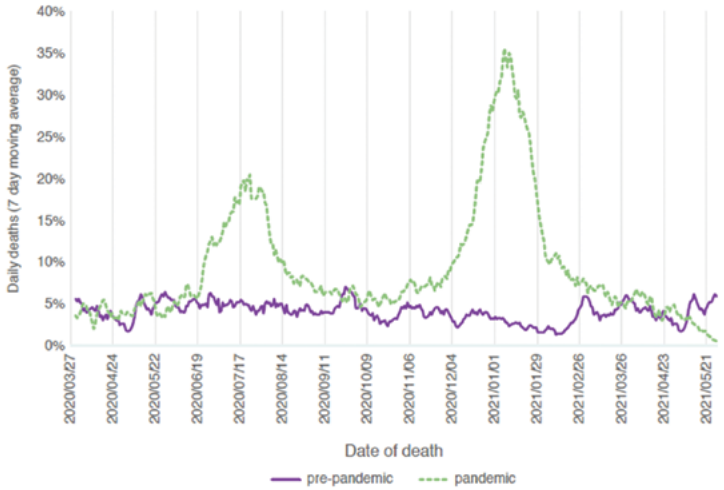
Another important indicator is the number of deaths in the education sector. The following table shows clear spikes when measured against pre-pandemic times. Some positive trends are emerging since the beginning of vaccinations, with educators being targeted and a successful roll-out programme beginning to mitigate the deaths. However, there is a reality that the country has lost over 2 000 teachers to Covid-19 prior to the vaccination roll-out.

[3] NIDSCRAM Wave 5 Report, Shepherd D and Mohohlwane N, June 2021

Daily teacher deaths in 2019 before the pandemic, and during the pandemic 2020/21



When one considers that there is already an educator supply crisis, between 2030 and 2040 the last educators trained in teacher training colleges will have reached retirement age. While university trained educators have only replaced educators lost to natural attrition, the loss of 2 000 lives will bring forward the educator supply tipping point. It is uncertain at this point when that will be, but the effects of shortages will be felt from at least 2030 onwards. In the meantime, learner numbers which have been less affected by the pandemic are expected to grow in the coming years. The increase in learners and the continued decrease in educators, with a looming dip in educator supply, spell a future of large classes and pedagogical deficits in the very near future.

6. Looking to the Future

The culture of care in Catholic Schools remains the most powerful vaccine against social and now health ills.

We have been careful to not enter the world of speculation and to avoid predictions, but in looking to the future, we can make the following observations. The Catholic Schools network through the immense efforts of learners, parents, educators, principals, national bodies such as CIE are weathering the Covid-19 storm. The investment in leadership and quality education prior to the pandemic has reaped results for the network.

While there is excellent analysis as provided in this paper from international and national studies, when one looks at the perspectives of the people closest to the learners, the level of detailed care is obvious. The culture of care in Catholic Schools remains the most powerful vaccine against social and now health ills. Should Catholic Schools continue under the current trajectory, we expect them to be able to face any future crisis.

We pay tribute to the many lives lost during the pandemic and keep all who have lost loved ones in our prayers.

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